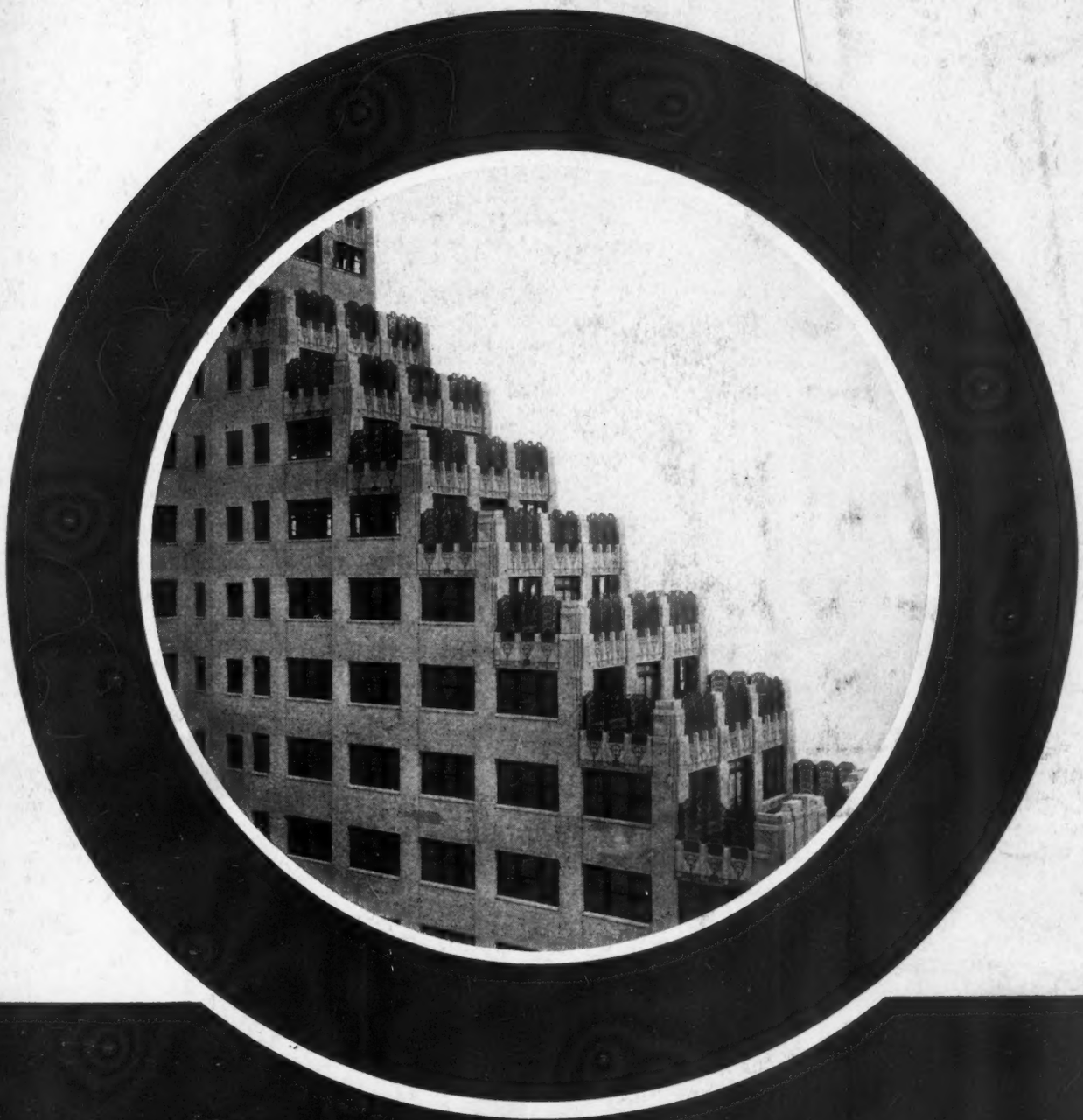
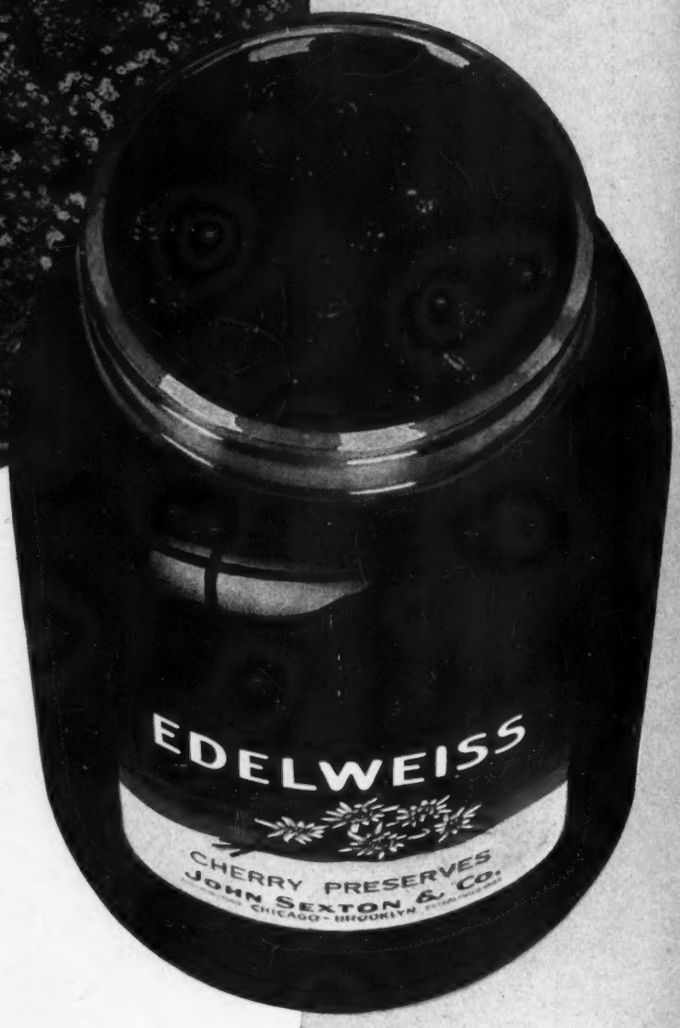


the MODERN HOSPITAL

VOLUME 47 SEPTEMBER 1936 NUMBER 3

From Sexton Sunshine Kitchens



THE SCHOOLBOY SMACKS HIS LIPS over the cherry jam on his bun—the traveler relishes the Inn's extra courtesy of jelly for his breakfast toast—the convalescent beams on the breakfast tray with its inviting service of orange marmalade. Because they all know quality, the enjoyment of each is heightened when the spread is Sexton's. Sexton preserves, jellies, fruit butters, and marmalades are sold in annually increasing quantities to those who insist upon the best. Time-honored recipes and careful selection of fruits insure your complete satisfaction with the products of Sexton Sunshine Kitchens.

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For September, 1936

Just in Passing—

"STEPS to Health," we might call the lacey grille work which makes the guard rail for sun porches at the Hudson County Tuberculosis Hospital, Jersey City, N. J. Our cover this month shows an unusual camera study of a section of the hospital's exterior.

NOW and again an editor is stumped. When Doctor Harmon's article describing the hospitals of Cleveland (page 66) was received, it contained the phrase "German Hospital d/b/a Fairview Park Hospital." That little symbol "d/b/a" intrigued us. What did it mean? Frankly we didn't know. But we determined to find out. The new Webster's dictionary, which has recently come to adorn the editorial department, although so often an aid, failed us this time. We concluded it was a typographical error. If so, it could be solved. So we tried various combinations on the typewriter, moving our hands one key to the left and one key to the right. No luck. Then we tried two keys to the left and then two the right. Failure. All we got was such hieroglyphics as "gmd" or "ac." Up and down were equally fruitless. So a contest was announced and stenographers, proofreaders and advertising salesmen invited to compete. Fortunately for editorial prestige the prize was unclaimed. Finally we queried Doctor Harmon.

This abbreviation, he replied, was in the material originally supplied. "I assumed that I must be dumb not to know such an abbreviation. On discovering that such an expert as you is unfamiliar with the abbreviation I

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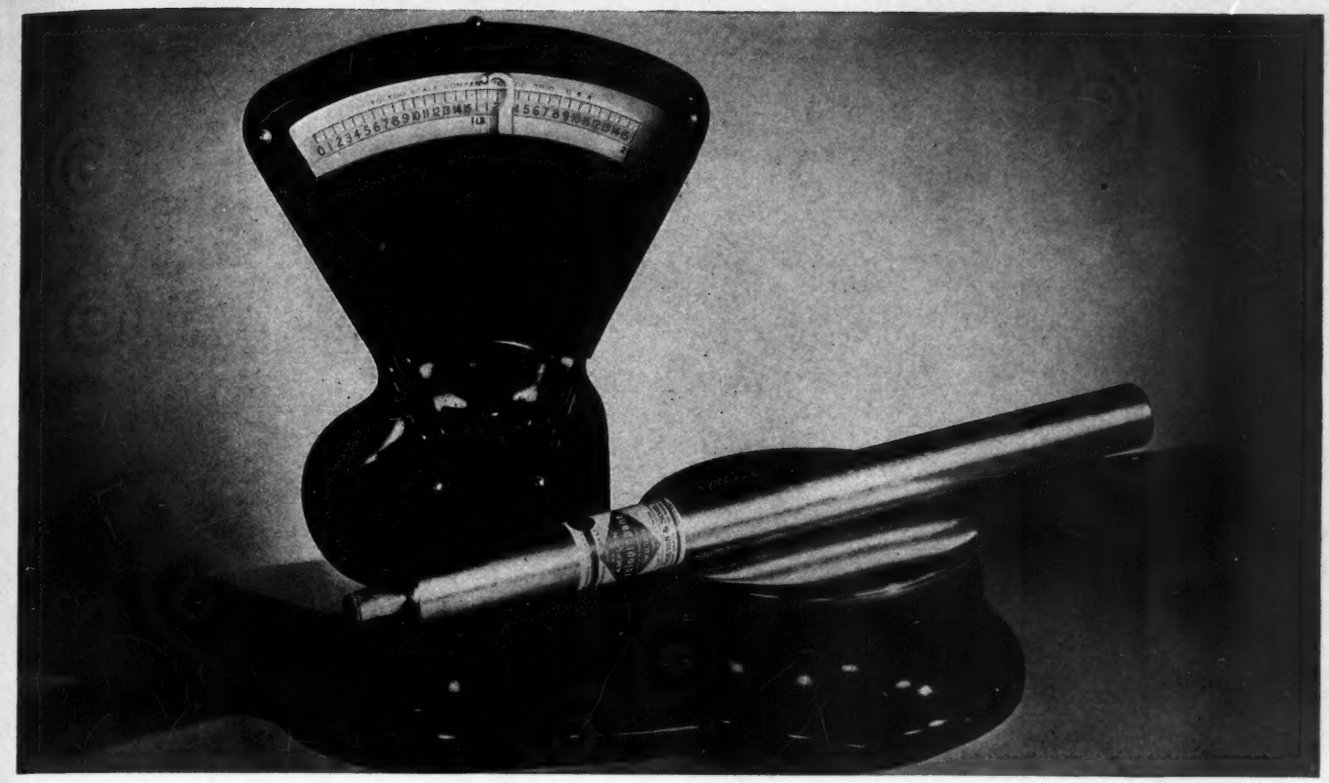
took occasion to call the hospital. They informed me that it is an abbreviation for 'doing business as'." And did we feel foolish!

WHAT is the key to hospital success? That depends upon your point of view. Some say it is excellent food. Others say that courtesy is most important. There are advocates of air conditioning, of publicity, of high grade nursing, of women's auxiliaries, of fine buildings and equipment, and of almost every other aspect of hospital work. Some claim that high quality teaching is the key to enthusiasm. Certainly all agree that two groups must be pleased: the patients and the doctors. Whether the one or the other is the more important depends upon many local circumstances. Certainly neither can be neglected. One way to please doctors that seems to be working successfully in both Henrotin and Passavant Hospitals, Chicago, is to provide space and facilities where they may see their private ambulatory patients and utilize fully the diagnostic and therapeutic facilities of the hospital. The latest institution to provide this extra service to the staff is Evanston Hospital. At a modest cost, Miss McCleery, the superintendent, has arranged a most attractive suite (page 54). If you are interested in the philosophy back of such a move turn again to the article by Dr. Nathan S. Davis III which appeared on page 61 of our October, 1935, issue.

THERE is much talk today, some of it rather loose, about "overeducated nurses." A nurse may indeed be overtrained in the sense that she has too much technical skill in certain routines and too much dependence upon equipment and standard procedures. But certainly she cannot be too well educated, since one of the basic functions of true education is to develop flexibility, adaptiveness and creative, original thinking. The brittle nurse who is the slave of her highly developed technique is at a serious disadvantage today. Nursing procedures are changing too fast for her. Next month Mildred E. Newton, instructor of nursing education, University of California Hospital, will outline changes as they affect the staff nurse.



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SOME months ago Dr. Herman N. Bundesen and Major Joel I. Connelly of the Chicago department of health presented in this journal the results of their extensive study of the dangers of faulty plumbing in hospitals. St. Louis, too, has been studying this problem. In a survey of four institutions by the health department over 1,000 hazardous or potentially hazardous plumbing defects were discovered. Next month W. Scott Johnson will present this material.

OF COURSE you are going to the convention in Cleveland. But whether you go or stay, you will find in The MODERN HOSPITAL next month a summary of the action there that will multiply your own observations several times.

"FOOD From a Gravel Pit" is the intriguing title of an article in next month's food service department. The article is just as instructive as it is intriguing.

GOOD news for the Shircliffe salad enthusiasts. Mr. Schircliffe has generously created a new series of salads for The MODERN HOSPITAL readers. The pictures and directions will begin next month along with some unusual pictures of — but why should we tell the whole story now? Look in the food department next month.

HAVE you seen the editorial on group hospitalization in the August 22 issue of the *Saturday Evening Post?* Once again the *Post* has done an excellent piece of work on a hospital subject.

FLASHES FROM THIS ISSUE:

"The reputation of the physician is secure, indeed, if he has a good nurse at the bedside and a good social worker in the field." *Page 52.*

"Hospital superintendents or their buyers have not always been quality conscious if one may judge by the heaps of nondescript equipment and furniture . . . hauled to the dump every year." *Page 94.*

"There is growing need for the most efficient use of every inch of floor space, for the rehabilitation of departments become obsolete in point of layout and equipment, for the introduction of new atmosphere reflecting changed attitudes toward patients and public alike." *Page 44.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
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919 NORTH MICHIGAN, CHICAGO, ILLINOIS

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The Hospital Barometer

Occupancy in nongovernment general hospitals continued at a high level during July, the preliminary figure remaining practically the same as for May and June. This year's figure is 6.7 points above last year's and 10.5 above the figure for 1934.

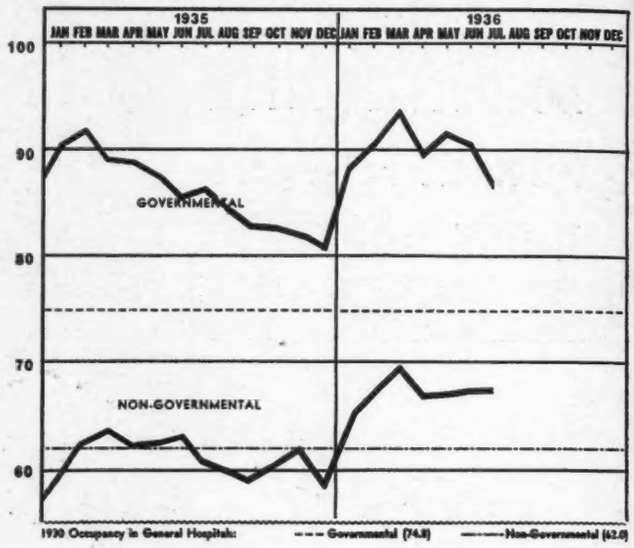
In government general hospitals occupancy dropped nearly four points in July, reaching practically the same figure as was recorded for July of last year. So far this year the occupancy in these institutions has been appreciably above last year's figures.

In accordance with the usual seasonal trend, new hospital building projects slumped in the month ending August 17 to a total of 33 projects, of which 31 reported costs of $2,820,000. Nine of these were new hospitals costing $890,000; 23 were additions to existing hospitals of which 21 reported costs of $1,905,000, and one was a nurses' home to cost $25,000. This is the lowest total of new hospital building projects reported during any month this year but the total since January 1 ($69,810,000) is still well up from the two preceding years.

Industrial activity during July reached a new high level for the recovery period, according to the monthly business survey of the National Industrial Conference Board. The most notable expansion took place in the building industry, with total contracts showing an increase of 26.5 per cent over June, as compared with a usual seasonal decline of about 9.3 per cent. Machine tool orders rose to a point only 3.7 per cent below the 1929 average. Less than seasonal declines occurred in the automobile and steel industries. Electric power output advanced to a new high record. The increase in bituminous coal production was greater than normal, although crude petroleum output declined moderately. Substantial improvement occurred in the textile industry and distribution and trade indexes reflected further gains.

The general wholesale price index of the *New York Journal of Commerce* advanced from 81.2 on July 21 to 82.8 on August 24 (1927-1929=100.) Grain prices advanced very rapidly during this period, the index going from 92.9 to 107.7. Since the index of grain prices was at 80.7 for the week ending June 23, these prices have advanced 27.7 points in two months. Other foods have not advanced so rapidly, however, and the general food index moved only from 79.0 to 81.6 during the month under review. Textiles and building materials dropped in price slightly and fuel began its seasonal advance, going from 79.7 to 81.1 during the month. The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* advanced slightly during the month.

The continued drought has already caused many advances in food prices and may result in more. Further discussion of its effects will be found in the food service department in this issue (page 106).



OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

Type and Place	Census Data on Reporting Hospitals[1]		1935						1936						
	Hospitals	Beds[2]	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July
Nongovernmental															
New York City[3]	68	15,194	66.0	62.0	62.0	67.0	69.0	66.0	71.0	75.0	77.0	75.0	76.0	76.0*	76.0*
New Jersey	57	9,772	62.0	60.0	60.0	62.0	63.0	62.0	66.0	70.0	69.0	66.0	66.0	64.0	64.0*
Washington, D. C.	9	1,792	68.2	62.0	63.9	68.3	68.3	63.0	70.8	77.5	78.4	71.2	70.9	73.2	71.6
N. and S. Carolina	103	6,328	65.7	66.3	65.7	64.4	63.3	59.1	63.9	67.1	68.7	64.9	65.0	67.3	69.0
New Orleans	7	1,146	57.1	58.2	55.1	53.3	55.8	50.8	58.3	56.9	62.5	58.2	61.2*	63.0	64.4
San Francisco	16	3,098	62.4	63.9	63.9	66.7	70.2	65.2	71.9	75.6	71.7	72.3	70.6	70.6*	72.9
St. Paul	7	838	46.4	49.1	48.5	46.6	50.7	49.0	56.7	57.2	61.1	58.8	57.6	58.2	54.6
Chicago	28	5,542	54.5	53.8	53.6	54.7	54.9	52.8	56.5	61.4	63.9	63.1	64.6	63.9	58.3
Cleveland	7	1,183	63.2	63.4	58.5	61.7	62.3	60.6	66.5	68.3	72.2	72.9	73.6	68.3	74.6
Total[4]	302	44,893	60.6	59.9	59.0	60.5	61.9	58.7	64.6	67.3	69.3	66.9	67.0*	67.2*	67.3*
Governmental															
New York City	17	12,042	103.6	93.2	91.7	85.8	86.5	87.3	95.1	100.2	98.2	95.8	100.4	90.3	87.1
New Jersey	5	2,122	79.0	79.0	76.0	84.0	78.0	76.0	80.0	84.0	84.0	81.0	84.0	82.0	82.0*
Washington, D. C.	2	1,596	68.4	69.5	62.9	60.4	60.4	62.9	71.4	73.3	68.9	66.7	62.9	65.5	65.5*
N. and S. Carolina	13	1,358	68.7	72.3	68.0	66.9	65.4	63.8	71.4	73.2	75.8	71.8	73.0	75.2	72.0
New Orleans	2	2,227	149.0	143.1	140.9	138.5	137.4	127.8	130.0*	141.3	169.8	146.2	164.2	168.2	148.1
San Francisco	3	2,285	72.0	71.3	79.5	76.8	79.1	81.1	83.5	83.4	79.2	81.2	80.9	80.9*	88.1
St. Paul	1	850	67.3	63.4	61.5	65.0	68.6	66.6	94.9	85.4	84.5	82.7	80.0	77.9	69.6
Chicago	2	3,730	83.5	80.5	80.4	81.7	80.2	79.5	83.3	86.0	87.9	87.2	85.2	83.5	81.4
Total[4]	45	28,180	86.4	84.0	82.6	82.4	81.9	80.6	88.7*	90.8	93.5	89.6	91.3	90.4*	86.7*

[1]Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. [2]Including bassinets, in most instances. [3]Includes only general hospitals. [4]The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

The Editor Talks It Over

• Points of view change with each passing year. Time was when to retail anything but medical service within the hospital was considered something less than dignified. Today, many hospitals have nooks with such unique names as "The Corner Cupboard," "The Rendezvous," "The Cozy Corner" and a score of other attractive designations where flowers, candy and the hundred and one other articles required by the hospital's personnel and its visitors are displayed for sale.

Many of these miniature stores are unusually inviting and original, displaying more than a modicum of window dressing and sales skill. Others suggest the ill-kept and unkempt cigar store on the corner of cheaper sections of a large city.

The ladies' aid or some other similar group frequently is the storekeeper. From this venture there may accrue a comfortable profit to be used for the maintenance of the social service department or some other hospital activity. In not a few hospitals of 200 beds or even less, the profit on this little merchandising activity reaches $100 or more a month. Whether such a plan is fair to merchants near by is a matter of opinion, and likewise whether it should be conducted as a concession or wholly by the hospital. It is sufficient to remark the financial success of most such efforts.

• One has but to glance through the interesting pages of the official journal of the Frontier Nursing Service, published at Lexington, Ky., to appreciate the luxury of caring for the sick in the average well appointed hospital of today. The mountains of Kentucky in winter time present a strenuous background to the practice of medicine and nursing. Obstetrics particularly, because of its basic requirement of a high degree of antisepsis as well as promptness in response to a call, presents to such a service a difficult problem.

The delivery of a thousand women in the midst of the most primitive surroundings without the loss of a single patient is certainly a splendid record and one which should find acclaim far beyond the modest pages of the Frontier Nursing Service's publication. What a contrast to city practice is this: the necessity of employing horses as the one means of transportation for doctors, nurses and supplies in their trips across icy mountain streams, s w o l l e n from spring rains or solid from winter's freezing, and along roads that are nothing but mountain paths! To have rendered such a service amid all of these handicaps calls for a degree of heroism and physical hardihood infrequently demanded of the average hospital worker.

Comment relative to the splendid medical and nursing work performed in the Kentucky mountains would not be complete without particular reference to the part that the faithful horses of the Frontier Service play in bringing it about. Each with a name and a record of valor, they are almost as important to the accomplishment of this work as members of the human personnel. Lassie and Traveler and Dixie and Gipsy King are names that well deserve to be set down in that invisible volume in which the splendid traditions of hospitals, of doctors and of nurses are recorded for the encouragement of future generations.

• Fall and football are synonomous to many. Champion teams are never composed of men who act as individuals. It is the team spirit that spells success. Hospitals cannot be efficient if each worker acts on his own initiative. The signals must be called by the executive but the effect of the response depends on the training and concerted action of the group.

• Again speaking athletically, the baseball team which consists of a collection of past "greats" is less likely to win pennants than one comprised of young aspiring, near or some day stars. Youth is having its day in many hospital staffs. In one large institution the average age of the major staff is forty-two. To acquire a visiting staff from without or to train one—that is the question. The names of eminent physicians undoubtedly ornament the pages of an annual report, although their presence in the wards of the hospital may represent unusual events. Patients are not restored, however, by brilliant annual reports. Build a staff, do not buy one, appears to be a good rule to follow.

• Do you have in your institution a well organized bureau for the receipt and adjustment of complaints? The reaction that arises when complaints are received in a measure classifies the hospital as to its vision of service to the community.

If the superintendent or any of his official family displays irritation and discourtesy when a patient or his relatives complain, one should look carefully at the hospital organization to see whether a spirit of provincialism exists and whether a really honest desire for improvement is to be found there. Complaints, if constructive, should be welcomed; if destructive, courteously received. A promise of investigation should be more than a matter of words. Heads of departments should not be content to allow their assistants to assume the unpleasant task of adjusting such difficulties. This duty should be performed by the most understanding and tactful person available.

The follow-up letter requesting the opinion of a discharged patient as to the type of service that he had received is a useful method of learning what the community thinks of the hospital.

• To distinguish between principles and personalities often appears difficult. One likes or dislikes persons and their ethical, moral and physical attributes. This is often an involuntary and inexplicable individual reaction. Some personalities strike fire whenever they contact each other. It may be no fault of either. But the principle of right and wrong, wise and foolish, scientific and unscientific are unchangeable and enduring. The superintendent of the hospital who decides a question on the basis of whether he approves of those concerned fails as an executive because he mistakes persons for principles. It is difficult to force from view the irritating traits of human character. Yet always to be just, tactful and considerate of the feelings of others are factors in bringing about administrative success.

Looking Forward

Something Wrong

TWO recent news items, which were of interest in themselves, are made doubly so when considered together.

Last month these columns reported the demand of the newly formed San Francisco union of hospital and institutional workers that all porters, janitors, kitchen help and similar hospital workers receive a minimum wage of $75 per month and full maintenance. Of course the fact that such a wage has been demanded by a newly formed (and therefore probably small) union does not mean that San Francisco hospitals are actually paying it. It merely indicates the value placed by these employees upon their work.

Almost in the same mail comes a letter from a state hospital in search of a nursing supervisor. The woman required must be between thirty and forty-five years of age, thoroughly trained in psychiatry, possessing administrative ability, poise, tact, patience and capable of advancing to the position of superintendent of nurses and head of a small postgraduate training school in psychiatry. "The salary will be $80 a month with full maintenance to start with, advancement depending entirely upon the individual's efforts to handle the job."

The MODERN HOSPITAL does not quote this request with any intention of humiliating the hospital concerned or any nurse who may see fit to accept the offer. Many other hospitals are offering similar salaries. On the other hand, there is obviously something wrong if porters and kitchen maids are to demand and receive $75 and maintenance, while highly skilled nursing supervisors with splendid personal qualifications are expected to work for $80 and maintenance.

Probably the hospital has set its scale so low that it will not be able to obtain any well-qualified nurses for the figure quoted. Some hospitals are paying this much for nurses for general floor duty service. Most pay higher salaries for supervisors, especially those with postgraduate training in a specialty.

Improvement in general economic conditions is putting hospitals in a position in which they are able to pay better salaries. The increased demand for nurses will force us to meet their requests for better compensation or see our institutions depleted of their best nurses. These are trends that hospital administrators must consider in making up budgets for 1937.

Nurses' Association Approves

AT THE recent national convention of the American Nurses' Association, resolutions were adopted approving statements contained in the Manual of Essentials of Good Hospital Nursing Service prepared by a committee of the Council of the American Hospital Association. In this work the chairman and his committee were assisted by representatives of the several national nurses' organizations.

It is heartening to know that the American Nurses' Association approves of the recommendations contained in this useful manual. It is taken for granted that any steps which favor the better medical and nursing care of the patient will receive the acclaim of national nurses' and medical groups. It should not be necessary, however, to call the attention of the hospital field to the need for better living and working conditions and for adequate salaries for nurses. A well housed, well fed, well paid nurse is capable of rendering better service to the sick than one for whom inadequate living standards are provided.

Outside of the humanitarian argument, an appeal for better pay for nurses on any basis other than the welfare of the sick would smack of professional materialism. National nurses' organizations, if from the standpoint of expediency only, should cease incriminating hospitals as profiteers on the credulity of pupil nurses and should endeavor constructively to improve the education of the nurse by actively cooperating with hospital and medical associations in an effort to bring this about. If all those who care for the sick base every argument for improved educational and physical advantages

upon their favorable effect upon the cause of the sick, none may imply that individual comfort is the only end sought.

Hospitals generally do not deliberately inflict either educational or physical unfairness upon the nurse, although too often unfairness occurs. Neither doctors nor nurses nor even the hospital superintendent can perform the acrobatic feat of lifting themselves to higher levels of scientific or professional recognition by straining at their own boot straps.

Contagious Disease Experience

IN A certain voluntary hospital in which the pediatric department had suffered frequent quarantines, an affiliation for its resident staff was made with a municipal contagious hospital. The resident staff was given a three months' period of service in contagious disease as a part of its regular internship.

The effect upon the hospital in which these physicians served was startling. During a twelve-month period, fifteen cases of contagious disease were diagnosed and detained in the dispensary and receiving wards which under ordinary circumstances might have secured entrance into the hospital ward and hence have resulted in costly quarantines. In eighteen months, the pediatric department was closed only twice because of the development of a contagious disease there, and in each instance no rash was present upon admission nor were there any signs evident to denote the fact that a contagious disease was incubating.

Quarantines are costly both to the hospital and to the community. Exposure to contagion is a menace to life in the children's ward. The adequate training of interns and nurses in the detection and handling of contagious disease will pay large dividends in human life and in money to the hospital insisting that the personnel have this type of experience.

Golden Tact

IT IS far easier to master the science of the practice of clinical or administrative medicine than to perfect the practice of its art. Physicians, so it is said, largely succeed not only because they are learned in the treatment of disease but also because they are deep students of humanity.

The doctor who wields an expert scalpel but who clumsily plies his words is likely to receive only a small portion of the reward that his scientific skill should bring him. The physician who, in endeavoring to console a grieving mother who had lost prematurely her first-born, described the physical perfection of the fetus had much to learn in regard to that abstract thing called tact. The admission clerk, who, when asked about the necessity for a private nurse for a patient entering the hospital, replied that it would be well to see first how sick the patient became before deciding this question, was exhibiting the crudest variety of tact. The garrulous doctor or nurse who upon the least provocation describes to a sick man other patients suffering with a like ailment has delved only lightly into the book of human reactions to disease. The lugubrious intern, who expresses surprise at the hilarity of a preoperative patient by remarking that he has to undergo not a single but a double operation for hernia, needs much instruction as to the best methods of handling the sick.

Illustrations might be multiplied to demonstrate the fact that scientific skill and a high degree of understanding of the sick frequently do not go hand in hand. Perhaps the cause for such verbal conduct is to be found in a certain lack of breeding, of courtesy that should be taught in childhood days or even before. The fact remains that psychic wounds far more difficult to heal than those inflicted by the surgical scalpel could be avoided were tact a more common trait in hospital workers.

Mental Patient in General Hospital

NONE can deny the fact that the general hospital should be equipped to handle, at least in an emergency, all types of cases brought to it for care. In many hospitals this is the case. The treatment of surgical, medical, obstetrical and pediatric patients has become so routine a matter that few voluntary hospitals are surprised when they apply for admission and are embarrassed only when they exceed in number the beds available.

But what of the actively delirious or psychotic patient? What are his chances of finding an understanding and informed attitude on the part of the hospital's personnel and of receiving modern and humane treatment in the average general hospital?

One finds nurses and resident physicians whose experience and training in the handling of such cases are not likely to be adequate; even members of the visiting staff are often wholly

at sea in the presence of a manic patient. Restraints are likely to be of the crudest, most uncomfortable, most inefficient and dangerous type. Hydrotherapy is often conspicuous by its absence. Morphine and other even more dangerous and depressing therapeutic agents are too quickly employed to control the patient's physical hyperactivity.

Perhaps, the all too frequent occurrence in the general hospital of suicide by jumping or by strangulation reflects this absence of knowledge, this lack of mental disease consciousness, so often encountered in such institutions. The delirious or psychopathic patient deserves better at the hands of voluntary hospitals. Often in an emergency, care for a short period of time, until permanent placement can be secured, must be rendered by the voluntary hospital.

A partial answer to the problem appears to lie in obtaining for schools of nursing in general hospitals an affiliation with those of special institutions for the care of the mentally ill. The present situation deserves most careful consideration at the hands of medical, administrative and nurses' associations. Certainly, no patient more urgently requires treatment than does the manic psychopathic or delirious and with equal surety few receive less skilled attention in the average community hospital.

As We Get Out of the Woods!

A HUNGRY man is not likely to think out his problems in the cold light of pure reason and the man who feels that he may be hungry is in about the same boat. Agencies like hospitals which face their financial future with fear are also likely to be inhibited from the most effective use of brains.

This is only another way of saying that intellectual independence is closely linked with financial security. In the financial fright of depression days, hospitals have turned anywhere for succor. Now as the clouds lift a little, as some government hospitals face a little less niggardly appropriations, as voluntary hospitals receive more paying patients, there is more opportunity, and no less need, for intelligent planning for a more stable and more adequate financial foundation for our medical institutions.

Group hospitalization has been a measure which, while it did not begin during the depression in this country or in England, has developed rapidly during the last few years in the United States. Undoubtedly the interest in group hospitalization has been enhanced because of a sense of financial need on the part of many hospitals. But from the standpoint of the general public, upon whose comprehension of hospitals our institutions rely for their ultimate backing, group hospitalization is not a plan for financing hospitals, but a measure through which people of moderate incomes can secure hospital service on a self-sustaining basis without recourse to charity. Surely the desire and habit of self-reliance needs cultivation at all times. Certainly it should be stimulated at present.

From this point of view, group hospitalization is a measure in which the public's interest in more accessible hospital care, the hospital's interest in adequate and stable support, and the medical profession's interest in good service to a self-sustaining clientele should move along together. It is important that these three groups carry on clear and cooperative thinking. It is timely to think well and to think together, now that we can release our intelligence from insecurity and reduce our nightly fears of bogies under the bed.

Fair Play to Salesmen

WHEN his secretary notifies an executive that a salesman waits in the outer office, the reaction on the part of the administrator is often one of irritation, even of discourtesy. Some executives pride themselves on being efficient in the matter of exterminating salesmen.

Discourtesy and impoliteness toward one who is endeavoring to interest the hospital in some new product or better application of a standard article do not become the dignity of an executive of a great institution. Such a policy is, moreover, short-sighted. A good salesman often serves as a distinct educational factor in hospital work. He brings information concerning newer methods as practiced in the other hospitals he visits. He believes in the product that he is selling. Often he has enjoyed a far greater opportunity to learn about linens, rubber goods and scientific equipment than the superintendent himself. He deserves a courteous hearing and if he is a good salesman he will realize that the executive's time is valuable and will not consume too much of it.

The administrator will do well to listen courteously to the reputable salesman who visits his hospital. Oft-times by so doing, he will benefit his institution not only by saving money but also by keeping its equipment and supplies modern and efficient.

New Buildings for Old

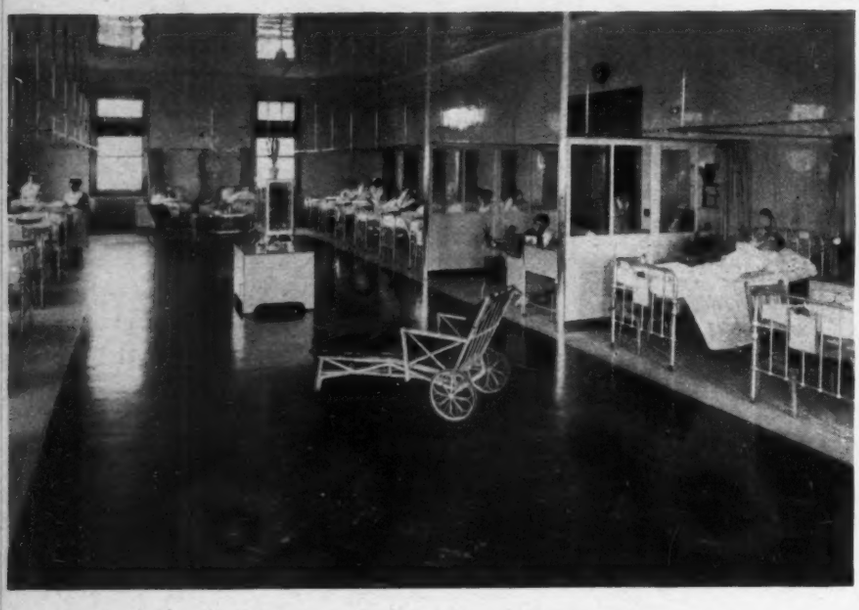
By RAYMOND P. SLOAN

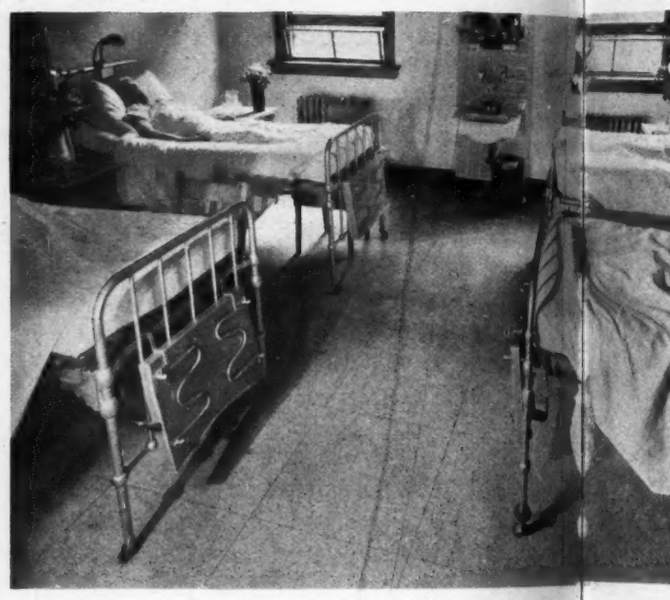
"WHAT shall we do about the old building?" It is a question heard frequently these days. Hospital service, if it is to advance, if it is to be maintained even, requires modernization. There is growing need for the most efficient use of every inch of floor space, for the rehabilitation of departments be-

come obsolete in point of layout and equipment, for the introduction of new atmosphere reflecting changed attitudes toward patients and public alike. The more necessary is all of this following a period when pressure of economic exigencies barred any extra expense whatsoever.

This question was of double import when presented for discussion at Mount Sinai Hospital, New York City, a year or more ago. Not only was one building involved, but two—each of them with thirty-five years of service behind it. During that time it was but natural that plumbing and water lines should have deteriorated and fixtures grown shabby and out of date. Then too, it was evident that space could be assigned to better advantage.

It was determined that something should be done about it—plenty, in fact. Plans were carefully prepared by the hospital's engineering staff, headed by John B. Cubberley, in conjunction with Dr. Joseph Turner, medical director. The staff of eighty mechanics and painters normally employed in maintaining the building was augmented by fifty, first-class craftsmen all of them, who executed the entire program with the exception of the tiling, flooring and acoustical treatment.

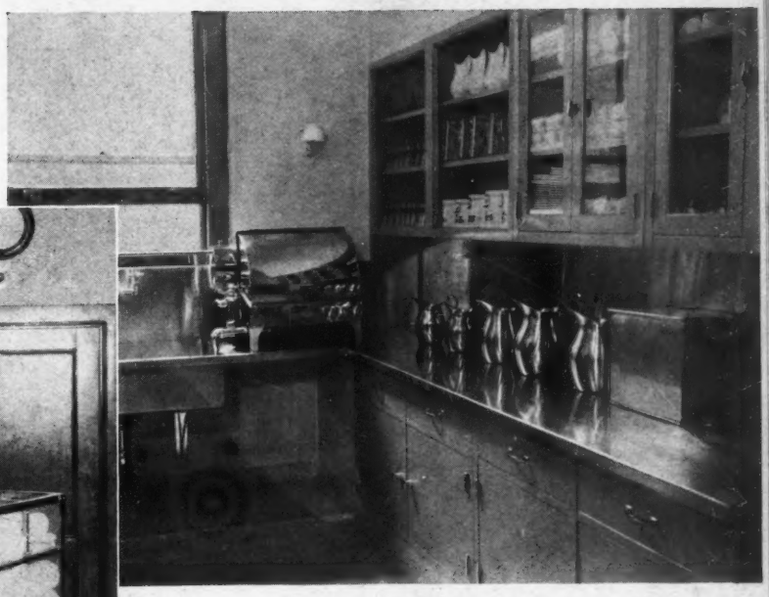




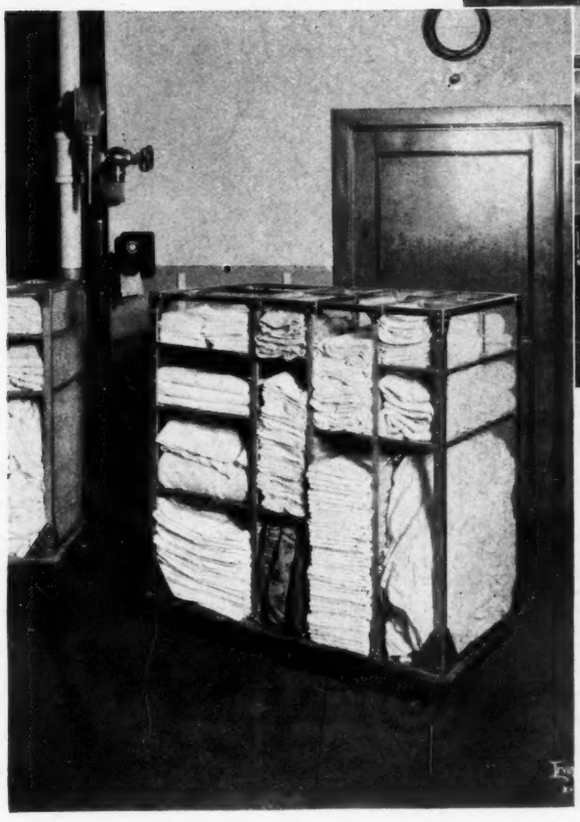
Old wooden floors in the larger wards were ripped out and replaced with magnesite terrazzo. The center area is 3/16-inch asphalt composition laid over a 1/2-inch underlayment of magnesite. Nurses stations are separated from the beds on either side by glass screens. Two new features incorporated in the smaller back wards are modern wash basins and glass ventilating screens in the windows.

Both of the buildings marked for rejuvenation are devoted to ward patients, one medical and the other surgical, having a total bed capacity of 389. The medical building comprises a roof which is used as a solarium, an isolation ward, five ward floors, a reception ward and basement. The surgical building also has a roof available for patients' use, four ward floors, a floor for administration and basement and storage area.

The problem presented itself of how to effect



On each counter in the pantries is a water power dishwasher. Steel cabinets have stainless steel counter tops. Ceilings are treated for sound absorption.



A close up view of the special portable linen closet. Frame work is light, of medium hard aluminum.

changes entailing complete renovation throughout at no sacrifice to the patients' comfort. This was finally accomplished by closing one building at a time, moving the patients to other floors when necessary, and curtailing the service somewhat.

The entire project, only recently completed, was a year in process. It has been accomplished at a total cost of $225,000. Of this amount $150,000 was expended on materials and equipment and the balance of $75,000 for labor. The two buildings contain 1,938,500 cubic feet of construction and the renovation cost was 11.5 cents per cubic foot.

Inasmuch as practically the same procedure was applied to both buildings, it is necessary to study only one to become familiar with this particular program of modernization which illustrates clearly how a thirty-five-year-old structure can be brought in line with the times.

There can be no better place to start than the roof. It has already been explained that the roofs of the two buildings are used for convalescent patients, the roof of the surgical building for men and of the medical building for women. The first step was to make them less roofs and more roof gardens by removing the copper parapets, which precluded any view, and substituting iron railing on cement capstones. Then the old sun porches were made more habitable by copper kalemine enclosures and a floor of magnesite terrazzo. The open roof was finally covered with red tile on which were set privets and evergreens growing in tubs, and flower boxes.

As the building stood originally there was an old balcony on the one roof upon which all rooms in the isolation section opened. This was removed, the openings closed and steel windows inserted. On the north end of the isolation roof four bathrooms were installed and the pantries completely rebuilt. These now boast of mechanical gas refrigerators installed below cabinets completely covered with stainless steel. In the isolation section a two-section sterilizer is provided. This makes it possible for blankets or linens inserted from the restricted area to be removed by porters from the opposite side.

In the surgical building are two wards of forty beds each for women and also two for men. Exactly the same layout is to be found in the medical service. One of the first steps in the mod-

On the women's floors, black and white is introduced effectively in comfortable lounges. The linoleum wainscoting in marbleized creams affords a striking contrast to the black floor.

ernization program was to rip out the old wooden floors in the wards and replace them with magnesite terrazzo. That is, magnesite terrazzo was used 9 feet from the perimeter and a $\frac{3}{16}$-inch asphalt composition floor applied to the central area laid over ½-inch underlayment of magnesite.

Numerous minor improvements then followed to add to the comfort of the patients and make easier the nurses' routine. Behind the nurses' stations additional basins are now provided. The stations themselves are separated from the beds on either side by glass screens low enough so that the nurse in charge can see every bed, but affording protection from drafts. A telephone is placed on the nurse's desk but the bell box is installed in the corridor. Each window in every ward now has glass ventilating screens.

The reference to windows suggests a novel method of keeping clean all window sills that may be used as shelves. A fibrous composition plate which fits the sill precisely is affixed to it by screws. This is hardly noticeable because it matches the color of the woodwork to which it is applied. Nothing will stain it and it can be cleaned with a damp cloth. The same procedure is applied to kick-plates on doors throughout the hospital.

The old time lighting fixtures were abolished, of course. Ward lighting is now semi-indirect with two circuits, one bright and one dim. Each ward also has six night lights below the bed level flush with the wall, and each bed is equipped with a special hospital type bed lamp. The smaller back wards have vacuum outlets connected with a central vacuum plant.

Another change destined to make the patient's life happier was revamping the nurses' call system. Now each ward bed can call the nurse in charge.

Throughout the building generally, waste space has been put to practical use. The removal of obsolete indirect heating ducts provided closet room in which to store housekeeping equipment such as brooms and mops, also stretchers and chairs. It was also possible to install a new ward bathroom on each floor.

Modernization was applied in detail. A glass-lined clothes chute takes the place of the former old-fashioned open hatchway. All projecting corners are protected with 4-inch angular plates concealed with paint. Brass and bronze hardware reappears completely disguised in chrome plating with the added distinction of being practically self-sustaining—no more constant polishing. This operations appears on the books at $5,200.

Those engaged in making old buildings into new will find in this study of the Mount Sinai rehabilitation project a solution to the problem of how to move beds in and out of doors too narrow to accommodate them. The hospital engineers are responsible for inventing offset hinges by which the door is hidden behind the opening, adding 2½ inches to the width.

It did not take long to rip out the old typhoid closets made obsolete by modern medical practice. These now become linen storage closets with shelves so arranged that a special linen truck, actually a portable linen closet, sent from the laundry with a day's supply, can be pushed into the closet under the shelves. Linen may be taken singly from the "truck closet" or the truck closet may be wheeled into the ward in the morning from bed to bed.

"Special" is used advisedly in describing these trucks, for they were planned and executed in the hospital's own shops, replacing fibre carts in which everything was packed regardless of its use

or number. The framework is medium hard aluminum selected for its lightness. The shelves are heavy ¼-inch mesh galvanized wire. The partitions are arranged so that each item is kept separate from every other, also each item is accessible to the nurse in charge. The compartments, too, are the exact size to fit the items for which they are intended.

The old pantries have been completely transformed with modern equipment. New porcelain refrigerators have been installed trimmed with stainless steel, and containing a drawer at the bottom for cracked ice sufficient for floor needs. New automatic gas toasters are provided. Under the stainless steel drainboards of the sinks are new lead-turned steel dish cabinets, and the steel cabinets selected have stainless steel counter tops. On each counter is a water-power dishwasher. Every pantry is tiled throughout and the ceilings are treated for sound absorption.

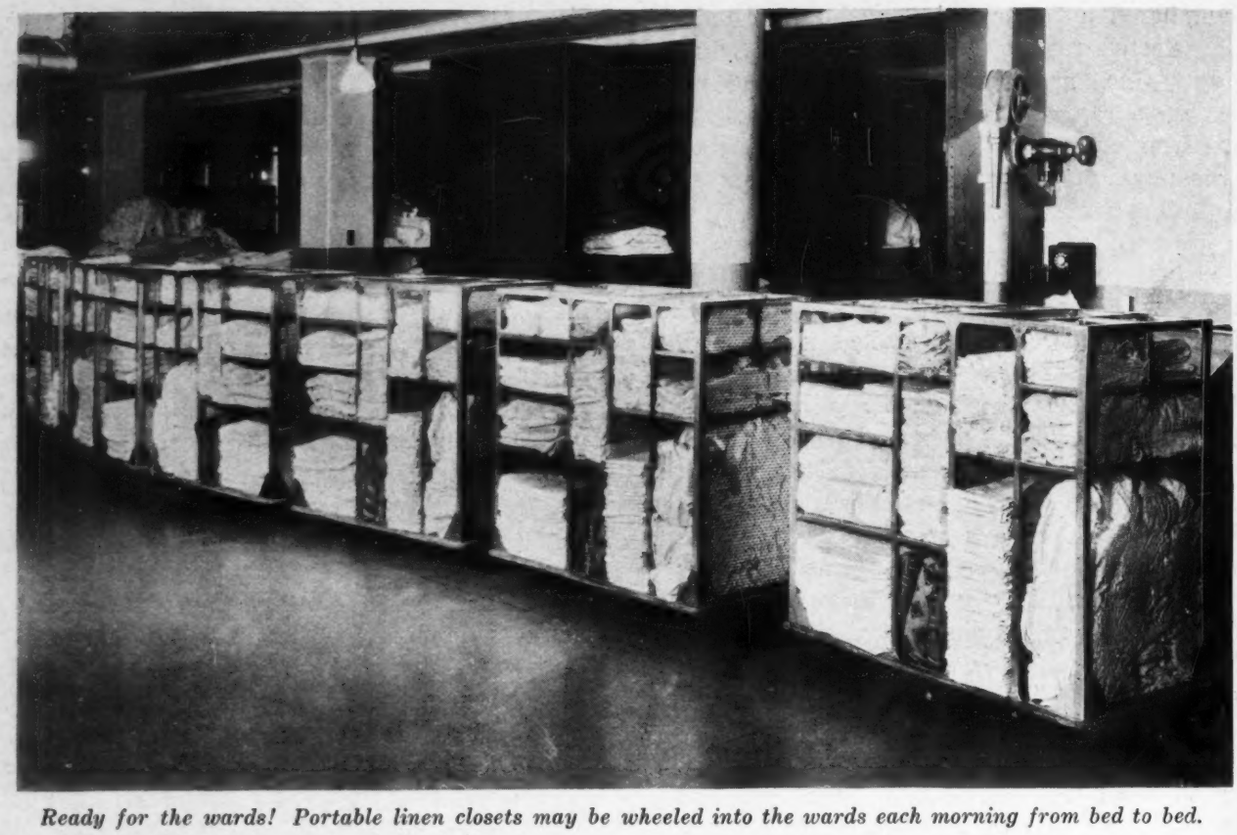
Time marches on in hospital building as in everything else. This is evidenced by changes made in the corridors. Ceilings are acoustically treated. A drinking fountain is now to be found on each floor. The old elevator fronts were abolished and replaced by new doors, which reduce noise and provide wider openings to accommodate modern chair equipment and food trucks. All portable equipment is supplied with rubber bumpers, lessening the damage to walls and doors. Even the old marble plaques on which appeared the names of donors of beds have disappeared, their places taken by dignified bronze tablets suitably inscribed.

Each floor in the old days had its day room, so called, a congregating place for ambulatory patients. These rooms were typically institutional, in line with approved standards of interior decoration as applied to hospitals in those times. But times have changed. Today these rooms are fitted as comfortable lounges, colorful and homelike.

On the women's floors, black and white is introduced effectively, supplying a delicate touch, decidedly feminine. A linoleum wainscoting in marbleized cream is used in striking contrast to the black asphalt floor, which in turn is lightened by a decorative cream strip. The walls are treated with a washable paper in a soft green tone, and are further decorated with flower boxes on brackets, also small aquariums in which goldfish disport.

The black and white note receives further accent in the woodwork, which is painted white with

Modernized pantries include automatic gas toasters and stainless steel equipment. New porcelain refrigerators have been installed trimmed with stainless steel and containing a drawer at the bottom for cracked ice.



Ready for the wards! Portable linen closets may be wheeled into the wards each morning from bed to bed.

black trim, and also in the wicker furniture, all white decorated in black, with the chairs furnished with black and white cushions. The light is softened by Venetian blinds and just as distinctly modern is the treatment of the radiators, all of them completely enclosed. Entrance doors are equipped with two chromium plated bumper bars to eliminate scarring by wheel chairs.

The men's lounge is just as typically masculine in its appointments. It is treated as an old-time hunting lodge, or club room, and executed in soft browns and dull reds. The linoleum floor gives the effect of brown tile. The walls, too, are linoleum, simulating pine planking from floor to ceiling and the woodwork is finished in pine. The furniture is maple with upholstery cushions in soft red and ecru stripes. Early English tables provide space for magazines and smoking paraphernalia. Full length ecru net curtains hang at the windows and numerous accessories create a homelike atmosphere. Maple wall brackets are designed in a violin shape and serve as electric light fixtures. Special indirect lighting is used for general illumination.

A two-channel radio receiver is installed in the men's and women's lounges, connected to the central system. Doors to the men's lounge are also treated with bumper plates but finished in bronze to harmonize with the decorative treatment.

Before leaving the corridors to inspect briefly the modernized basement, it should be noted that wherever possible some use has been made of old materials. In changing the plumbing, for example, all of the marble ripped out was salvaged and later cut up and used for shelves.

The electrical wiring throughout the two buildings had to be renewed and fixtures replaced. New panel boxes were installed, also new A. C. circuits pulled in.

Painting was a major item. A soft shade of cream, the result of much experimentation by the hospital staff and designated by it as "postcard cream," was used on the walls. The dadoes, formerly dark brown, are now a cool gray, and the elevator fronts are painted to match.

Now for a turn in the basement which also received its share of attention in the modernization program. The reception ward was completely overhauled, and an entirely new accident ward installed. All beds now have cubicle curtains. There are new public toilets, and also a suite of reception offices. The whole area has been treated for sound absorption, and a mechanical ventilating system introduced.

So a new era begins for buildings that already have thirty-five years of service behind them, made possible by a well conceived and carefully executed plan of modernization. The process of rejuvenation can be accomplished successfully, however, only when there is some foundation on which to work, coupled with a sound knowledge of logical procedure.

Administrative Case Histories

1. Blood Transfusion 2. Ward Surgery

3. Pay Roll 4. Social Work

By E. M. BLUESTONE, M.D.
Director, Montefiore Hospital, New York City

CLINICAL teaching is largely bedside teaching. An administrative clinic should by comparison be concerned with the practical rather than the theoretical side of administrative medicine. The apprenticeship method in teaching hospital administration, which is analogous to the clinical clerkship at the bedside and has many points in common with it, requires a daily succession of "clinics" in which textbook learning may be applied. We speak of the "principles" and "practice" of administrative medicine as we do in clinical medicine.

The purpose of this practical presentation is to single out a few selected incidents in the daily life of a hospital administrator which illustrate a teaching point that I have made on a number of previous occasions, namely, that most clinical situations require special treatment since they are to a considerable extent unprecedented. Unlike the worker in the exact sciences, the administrator cannot hope to be governed completely in his decisions by a repetition of similar cases occurring in series. No two incidents seem to be exactly alike when the administrator is called upon to depart from his executive and legislative functions and to enter the judicial field.

Handicaps of an Administrator

Before proceeding with the presentation of cases for your consideration, I should like to dwell for a moment on the key position which the administrator occupies in the hospital. This functionary begins life with a handicap. He must often say "no" when he wishes with all his heart that he could say "yes." He must always protect the interests of the group, while bearing the needs of the individual patient in mind. He is hampered by rules and regulations which, paradoxically, are largely of his own making. He has budgetary limitations. Indisputably, these are handicaps for men who must depend on good will, discipline and loyalty for their success and the success of their institutions.

In every organization one meets sooner or later individuals who will not take "no" for an answer and who manifest their displeasure in various ways. Some resort to protest. Others harbor the more or less permanent grudge. On rare occasions the reaction may involve downright sabotage. Assuming that the administrator has rendered a just decision, most of the dissatisfied are, of course, badly informed and cannot or will not see beyond their own noses.

The constable, the judge, the prosecutor, the public official generally, and all those who are charged with the maintenance of peace and discipline in the community, have their share of this psychologic burden. The actual hazard involved for the administrator is considerable since he combines in his own personality so many of these functions, while serving people who are sick and others who are well. The administrator who lives up to all the requirements of good leadership may expect to be looked upon at times, particularly by those who chafe under restraint, as the symbol of oppressive rules and regulations. There is no complete and infallible remedy for the situation. The administrator who would protect his office from the demoralizing inroads of the unfriendly critic, must be willing to make frequent clear statements of policy and explain matters patiently. This is a task which cannot always be carried out by deputy.

Good administration flows smoothly, freely and evenly. One might add in passing, that it is of some importance for the government of the hospital to be made as impersonal, in a sense, as possible. Every busy executive knows that "the board," at times, is a more effective argument than

"Doctor Smith, the superintendent." Where personal responsibility for decisions in controversial situations can be established, the obligation to give detailed and time-consuming reasons in rebuttal is often great. The right of a dissatisfied patient or employee to explanations when his comfort and well-being are involved is inalienable. The wise administrator makes every effort to earn a reputation for impartiality in crucial situations, while conserving his time and energy for the next problem.

The use of the governing board as a defensive screen has its place in administrative practice, but should be controlled since it cannot altogether replace the simple explanatory statement. The patient or employee may be well disposed toward "the board" but subordination does not encourage full confidence. This is only another phase of the handicap in hospital administration.

Let us begin with a few difficult case histories, taken at random from medical administrative situations in a large hospital.

Blood Transfusions

Enter the intern, with a request for permission to perform a blood transfusion on a ward patient. Expensive diagnostic and therapeutic procedure in well managed hospitals must be approved by the administration before being carried out. Approval is ordinarily withheld if the requisition is not signed by a member of the visiting staff. In this case, however, the administrative routine is correct. The form provides all of the required information and is properly endorsed. Now, blood transfusion is expensive and, with the exception of urgent cases where it is an immediate life-saving procedure, the administrator must consider the need from the point of view of funds available, assuming that a member of the family or a friend is not available to act as donor. (Hospital employees may not serve as blood donors in this hospital, except in great emergencies.)

The time was when blood transfusions were administered only in emergencies as life-saving measures. The typical case was the severe hemorrhage resulting from injury to a blood vessel. However, the indications have long since been extended.

We do, indeed, face a situation just now in which blood transfusions are sometimes administered for the psychic effect on the patient or his family and to prove that something is being done. This procedure has dramatic quality. It is admitted by clinicians that some blood transfusions are given indiscriminately and in disregard of scientific indications. In some instances physicians are apt to overlook the fact that more and more contra-indications to such transfusions have been discovered of late.

The administrator is justified in seeking evidence that the senior members of the visiting staff have considered the need carefully, after fully weighing the indications and the alternative therapeutic possibilities. No thought of expense should trouble the mind of the clinician in coming to a decision, though this phase of the problem is, of course, a matter of serious concern to the guardian of the budget, who must see that the finances of the hospital are spent for the greatest good of the greatest number.

A typical administrative contra-indication to transfusion would be lack of funds, though it is hardly conceivable that this would prevent the performing of a blood transfusion in an exsanguinated patient. It is the non-urgent case that we can discuss with the clinician and the one in which we can weigh the relative financial and clinical merits. No administrator would want to assume the responsibility of saying "no" in the presence of a positive and determined clinical demand, yet that is sometimes, though rarely, his plain duty. The ideal clinician, like the ideal employee generally, is the one who never puts you in a position where you will have to say "no" to him.

An examination of the section of the requisition in this case marked "diagnosis" reveals that the patient is suffering from a low hemoglobin, due to advanced inoperable carcinoma with metastasis. The object of such a transfusion is apparently to impress the family and perhaps keep the patient alive for a few more days. It differs somewhat from the requisition to x-ray all, or most, of the long bones of such a patient, in that the latter procedure is not intended so much to make an impression and prolong life, as to satisfy the natural curiosity of the clinician to whom budget means nothing at the moment of his greatest inquisitiveness.

How shall we decide such requests? The primary function of the hospital is to relieve suffering and to prolong life. "Never say die" is the typical motto of any hospital. It is obviously our duty to keep a hopeless patient alive as long as we can. I know that much has been thought and said and written on both sides of this delicate subject of late, especially in England, but our primary duty toward the sick remains unchanged. Who knows but that tomorrow will bring a cure. The removal of pernicious anemia from the field of advancing and incurable disease came, like most discoveries, suddenly. The administrator who would have refused a blood transfusion the day before to a patient dying from pernicious anemia on the ground that his case was hopeless, would have

been in a bad way the day after to explain himself to his conscience and to the community.

Four parties are involved in the final decision: (a) the patient, on whom all effort must be focused, (b) the clinician, on whom we must rely for expert opinions, (c) the administrator, who must say "yes" or "no" in the full knowledge of his limitations and (d) the community, which must provide the funds on request if the patient himself cannot do so. Where the patient can finance his own treatment the question does not reach the administrator. It is the poor patient for whom the community must provide.

In preparing his budget for the year the administrator is well advised to take the clinician into his confidence before settling on a proper balance in his expenditures. Clearly no item should be disproportionate to the probable needs of the greatest number. With this thought in mind, we will return the requisition for blood transfusion for further consideration and request the chief of the division for a personal review of the facts in the case, in the light of our discussion.

Ward Patient Surgery

The next case is that of the house surgeon who is displeased because the visiting staff is not assigning major surgery to him in accordance with the best traditions of his position and his needs as he understands them. He respectfully draws attention to the fact that his predecessor had been permitted to perform almost one hundred major operations during the course of his houseship and that this generosity had been discontinued shortly after he came into his present position.

How can a man learn the technique of major surgery, he asks, if he is not given opportunities in the operating room on ward patients? There is apparently a sufficient amount of teaching material on hand, besides a teaching staff that is not given to favoritism to guide and to supervise him. All of the circumstances being favorable, why is he not given the experience that is universally given to men in similar positions in this and other hospitals? A young surgeon must start operating sometime, he pleads, and the best time is his surgical internship, when he can learn under the best auspices, without the handicaps of private practice.

This man was selected on a competitive basis, purely on merit, and has as high an academic record, as noble a character and as pleasant a manner as the most sanguine administrator or surgeon could desire. Questioning the house surgeon carefully elicits no clue to explain the apparent difficulty. However, the administrator must be judicially minded and must not jump to hasty conclusions from a onesided presentation of a complaint.

We learn from the visiting surgeon that, although the qualifications of the house surgeon are of the highest in almost all respects, he is lacking in one essential qualification—that of mechanical ability, and this is fatal to his surgical ambitions. In the opinion of his seniors on the surgical visiting staff he should be discouraged from pursuing a technical career in this exacting specialty. On the other hand, he is a fine diagnostician and a successful therapist in nonoperative cases and should be encouraged to find his way in other fields.

Great care must be taken not to exploit the ward patient for educational purposes. The indiscriminate performance of major operative surgery by an intern, even under supervision, is to be condemned. The discriminating administrator and surgeon will carefully select teaching material and make the most of it, for the benefit of those who have special talents in certain directions.

It should count heavily against an institution if interns are provided with major surgery as a routine feature or as a reward without regard to their technical efficiency. Highly specialized work should be assigned to the intern in accordance with his ability to profit by it, without detriment to the service.

It is for the administrator and for the surgical staff to review the house surgeon's complaint with him as tactfully as possible, and advise him which path to choose in the field of medicine.

The Pay Roll

Mr. X is a nonprofessional employee who has been working in the maintenance department for many years and whose efficiency and general good conduct no one has ever had occasion to question. He earns a meager salary, somewhat less than he would receive in industry, and supports a small-sized family on his income. He is threatened with a decrease in salary as part of a major hospital economy program and this menaces him at a time when he can least bear it. His appeal is forwarded to the administration through the head of his department and the manner of its transmission bears all the marks of correct hospital practice.

Workers in the hospital field, whether they are in the professional or nonprofessional classification, have always had it to their credit that they were willing to serve the sick at lower salaries than they could earn with the same qualifications in commerce and industry. The "receiving public" has good reason to be grateful for this attitude, which is a survival from earliest days when serv-

ice of such a kind was given by men and women on a volunteer basis out of devotional motives. To this essentially humanitarian field of service the sordid motive of commercial profit is distant and the worker may enjoy the comfort of knowing that his contribution is, in some measure at least, philanthropic.

The medical staff furnishes its services almost completely on a volunteer basis. The nursing staff is so organized, from the standpoint of hospital economy, that the charge of exploitation has been leveled repeatedly against most of the voluntary hospitals, *i.e.* the "contributing public," in which they are employed. To a lesser degree there is underpayment of the technical and clerical staff. It seems, therefore, that these groups of communal workers should be given particular consideration when the governing authorities of hospitals find it necessary to adopt measures of financial retrenchment to balance the budget.

There are many sources of hospital income. In the voluntary hospital one of the most important of these is the ability and willingness of the philanthropic public to give. On the other hand there are many varieties of hospital expenditure. The pay roll is the most important one of these and it is here that a single stroke of the pen will bring about the greatest economy.

The natural tendency in difficult times, though not the fairest one, or the safest, is the transfer of more of the burden of support from the contributing public to the hospital worker, whose silent contribution in the form of comparatively lower salaries will thus be increased. The solution of this problem is in the hands of those who are charged with the task of financing the hospital, but the presentation of the problem, in as fair and unbiased a manner as possible, belongs in the province of the administrator.

Again, as in the case of blood transfusions, comparative values in proportioning the budget in relation to community needs must be borne in mind, while studying the labor market. Here is another opportunity to publicize the financial needs of the hospital.

The Social Worker

The chief of the social service department complains that one of the senior attending physicians of the hospital has made the statement at a meeting of the medical board that "the social service department should mind its own business (about which he apparently knows little) and get patients discharged promptly when they are asked to do so by the visiting staff." The administrator makes a mental note of the fact that someone has violated the confidential character of the discussions of the medical board and attempts a solution. If the complaint is well founded the physician in question is ill-informed and does not see beyond the bedside. The social and administrative points of view in the treatment of a patient are either unknown to him or they are ignored, in very much the same manner as he has ignored the rules of courtesy to his colleagues.

Here obviously is an opportunity to educate the staff. It is important to discover, first, whether there exists an underlying antagonism which has not yet been brought to the surface. In this case, however, there is no ill-will. So the administrator, in substance, speaks as follows:

The popular conception of the social worker is that of the Salvation Army lass, who has dedicated her life to make others happy, while foregoing those opportunities for joy which, if taken, might disqualify her for humanitarian service in the eyes of her fellows. To some people, and this includes a few physicians, her contribution toward the recovery of the patient is unknown, the possibilities of organized hospital social service having been discovered only within our own generation. The scientist, instead of complaining, should be speaking of "social service by prescription" and learning more about its possibilities and its limitations. He must not expect the patient to be taken off his hands as soon as he has definitely discovered the effects of operation or of medication, to make room for the next subject that may stimulate his interest. There is a transition period, which is mostly one of adjustment, between the hospital and home.

It is literally impossible for the modern physician to practice his profession without help in one form or another from the social worker. Under these circumstances the doctor is the medical technician working in an atmosphere of social service, thinking beyond his prescription of medicine or the surgical operation. The major portion of any "cure" is a social matter which has broader and more fundamental implications than the actual medical and surgical treatment of a case. Medication for a given patient may or may not prove to be remedial. A surgical operation may or may not prove to be successful, but medical social service, without exception, always produces beneficial results.

The reputation of the physician is secure, indeed, if he has a good nurse at the bedside and a good social worker in the field. Although the social worker is always there, she is often in the background of the picture so that one is apt not to take notice of her if he tarries too long over the brighter and more spectacular colors on the canvas.

Time on Their Hands

By C. W. MUNGER, M. D.
Director, Grasslands Hospital, Valhalla, N. Y.

PROVIDING activities for the leisure time of from fourteen to sixteen hundred persons is without question a considerable problem, but it has been well solved at Grasslands Hospital, Valhalla, N. Y., where library facilities, craft work, physical education, organized entertainment and an educational program are utilized by the majority of patients, staff and employees.

A reading room open to the entire hospital is in the main auditorium. Nurses have a private reading room in their home as do doctors in the resident staff quarters. These are all supplied with books, newspapers and magazines that have been purchased or donated.

The institution has two professional libraries. The Grasslands library of medical and hospital literature, in the main building and open to doctors, dietitians, nurses and other professional workers, has 800 books and subscribes to thirty-five current professional periodicals. It maintains branch bookshelves in such principal departments as psychiatry, tuberculosis, x-ray and laboratory. The school of nursing library contains books and periodicals on nursing and related subjects.

Books, magazines and newspapers are circulated among patients, with particular attention to patients who remain for long periods of time. These are donated to the hospital, which now has about 5,000 books. A separate supply is used for tuberculous patients. Books are distributed almost entirely by volunteers.

The patients' educational library has been established through the Minnie Cohen Library Fund. It is housed in the school at Sunshine Cottage in charge of the head teacher.

Radio and Movies Provided

The hospital has a central radio system with over 500 outlets for headphones at patients' beds. About eight regular radios are installed in children's wards and for others who cannot use headphones. Radios have also been placed in the recreation rooms of all employees' quarters, and many employees have radios in their own rooms.

Talking motion pictures are shown once each week in the main auditorium for ambulatory and wheel chair patients and for employees. There is no charge for these shows and about 200 persons attend. The hospital owns one 16-mm. projector for use in showing medical films and occasional educationals and comics to the children when there is money enough to rent these. Once or twice a month plays or concerts are presented by volunteer community groups in the main auditorium.

The occupational therapy department of the hospital provides interesting handwork for patients when prescribed by the physician in charge. If a patient's products are sold, he receives part of the proceeds. He may retain any article he makes if he pays for the material used in its manufacture. About 150 persons take part.

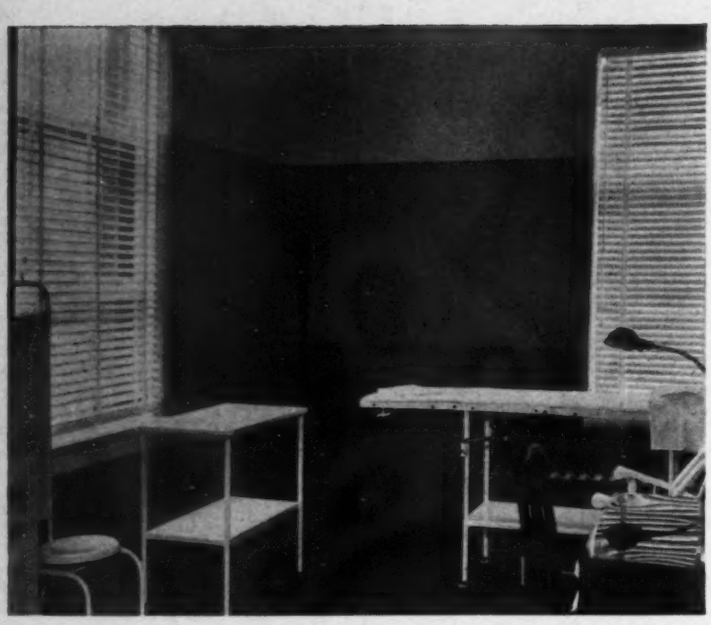
Chances for Study and Sports

The educational program at Grasslands is varied. The Sunshine Cottage Primary School has sixty pupils, while fifty adults are enrolled in the adult education classes for the tuberculous. Thirty-five children in the main building receive bedside instruction. Medical meetings and lectures are a daily occurrence with up to 150 doctors participating, and lectures on cultural subjects are provided for employees by their association.

Swimming activities are open to employees, and upon special arrangement to such community groups as boy or girl scouts. There were about 18,000 swims in the pool during 1935, probably more than half by nonemployees. No charge is made for the use of the pool. The Westchester Work Relief Bureau provides life guard instructors.

The gymnasium is open to all employees, and work relief here provides a part-time instructor to conduct regular classes. Basketballs, weights, medicine balls and similar equipment are available. No record has been kept of the number of employees taking advantage of the gymnasium.

Three tennis courts are in constant use during the summer. The one horseshoe court has proved so popular that two more are planned. Employees have organized baseball teams and play on a regular field laid out on the grounds. A near-by golf club has reduced its green fees to interns, and the 500-acre county reservation offers excellent facilities for exercise in walking on roads and paths.

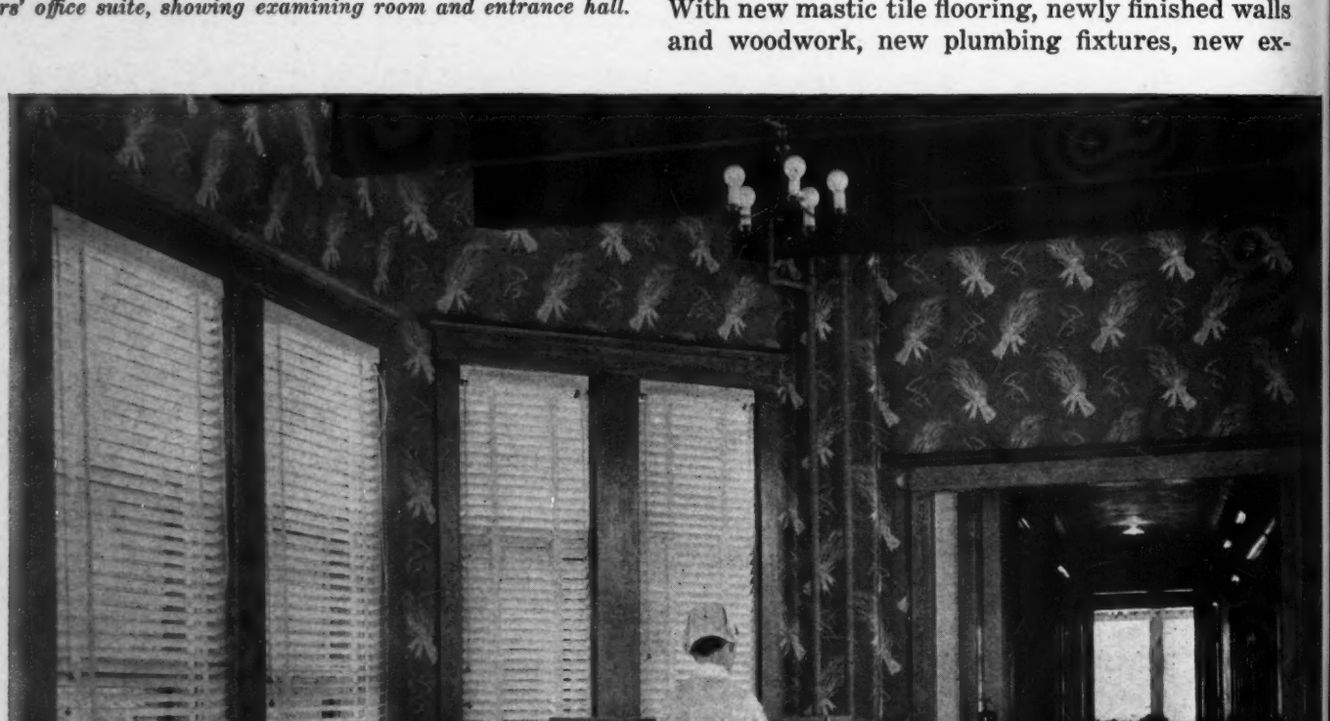


Doctors' office suite, showing examining room and entrance hall.

Evanston Opens Its Ne

FOR the convenience of staff physicians and their patients, Evanston Hospital, Evanston, Ill., has transformed one floor in one of the oldest buildings into a group of offices in which staff men may see their private ambulatory patients.

"Transformed" is a word hardly strong enough to describe the change that has been effected. With new mastic tile flooring, newly finished walls and woodwork, new plumbing fixtures, new ex-



New Staff Rooms

amining tables and other office furniture, all carefully chosen by the hospital's superintendent and an interior decorator, no one would suspect that the offices were housed in a building built a third of a century ago.

Patients entering the suite are greeted in a small room, which really is merely a widened hallway connecting the old Cable Building to the main hospital. One of the two nurse technicians assigned to the department is on duty here and it is here that the files are kept and appointments can be made.

An attractive wall paper, with a cocoa background relieved by white and blue figures adorns the hall. The woodwork has been "antiqued" with a soft grayish color that harmonizes with the wall paper. Even the files and office furniture are in the same soft cocoa shade.

There are ten examining rooms in all, each of them finished in a distinctive color scheme. All tend toward the modern, and in several instances the color of the ceiling has been carried down on the wall opposite the entrance door. Each of the examining rooms has an examining table, a desk and chairs. Doors have been removed from the closets and they have been converted into washrooms with modern lavatories and towel racks.

One of the examining rooms, formerly a floor kitchen, has been made into a special room for urologic work. It alone has a terrazzo floor. There is also a bathroom and toilet for use of patients or staff, as may be needed.

Total Cost Not High

At the far end of the suite is the waiting room, formerly a solarium. An imitation fireplace was removed and the room has been fitted up most attractively with modern furniture.

There is also a laboratory in which the nurse technicians may make simple tests for the staff doctors. Complicated examinations, of course, are sent to the hospital's main laboratory.

The total cost of the "transformation" is approximately $4,000, distributed as follows: mastic tile for 2,300 square feet and other floor repairs, $750; examining tables, instrument tables, laboratory equipment and similar equipment, $1,600; 40 Venetian blinds, $325; new tile and plumbing fixtures for examining rooms, bathroom, and laboratory, $1,100; miscellaneous, $225.

No charge is made to staff physicians for the use of the offices but they are charged for laboratory, x-ray and physical therapy work and for drugs and dressings. The nurse-technicians are available to make appointments, to act as chaperons and to assist the doctors in similar ways but it is not expected that they will have time to act as private secretaries or general office nurses.

Files have been provided in which doctors may keep patients' records and the hospital supplies regular forms such as are used in the out-patient department for the doctor's use. The character and completeness of his records, however, will depend upon himself as the hospital is not attempting to take responsibility for the records.

Doctors Take to Idea

The hospital decided to provide staff offices only after long study of the idea and observation of its effect in other hospitals in the Chicago region.[1] The new development is especially valuable to the staff of the Evanston Hospital because many of the men maintain their principal offices in Chicago or in one of the North Shore suburbs but have patients in or near Evanston. This plan permits them to have an Evanston office to the extent that they need it without any expense for rent, light, heat, basic equipment and simple clerical service.

The hospital expects that the increased use of its diagnostic and therapeutic departments and its drug room will bring in enough additional revenue to compensate for the investment and defray the extra salaries and expenses. Furthermore, it will give the staff physicians an even greater interest in the hospital.

The suite of offices was opened on July 6, and the response from the medical staff has been most enthusiastic. During the first three weeks a total of 192 patients were seen and twenty-two doctors used the new facilities.

The space occupied by the doctor's suite formerly housed twenty-two beds in the surgical department. By rearrangements in various other parts of the hospital a total of fourteen new beds were provided so that the hospital has suffered a net loss of only eight beds. The institution has a floor of twenty-two beds in another building which will be opened this fall, space used several years ago for housing personnel.—A. B. M.

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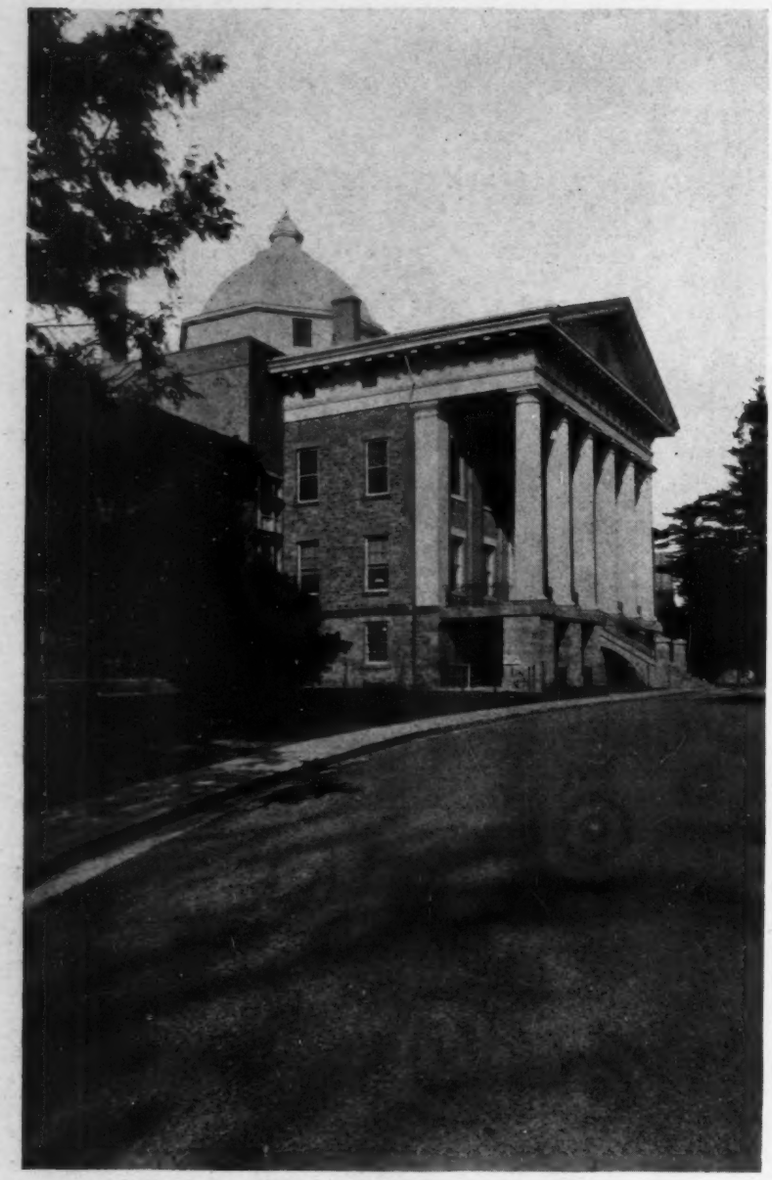
[1]Cutter, Irving S.: Hospital Extension Service Benefits the Patients, the Staff Men, the Hospital, The MODERN HOSPITAL, Feb., 1936, p. 64; and Miller, Veronica: Henrotin Blends Beauty and Service, The MODERN HOSPITAL, May, 1935, p. 47.

Good Will Toward Mental Hospitals



By ELLEN C. POTTER, M.D.

Director of Medicine,
Department of Institutions and Agencies,
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IN THESE days of reduced government income, of increased demands for public service to the economically and socially handicapped, and of bitter realization on the part of the taxpayer of the heavy costs to him of all governmental activities, it becomes increasingly important that there shall be complete understanding on the part of the citizens of the community of the need for and the quality of public welfare services if the standards of effective service are to be maintained.

The public mental hospitals were established generations ago in order that men and women mentally ill should be sorted out from among the individuals in our correctional institutions and almshouses and given a type of care more suited to their needs.

That this type of care was generally custodial, with relatively little treatment as we know it today, accounts for the fact that such institutions were set apart in the public mind as places of horror to which one feared to be sent, and to which one's friends did not willingly come to inquire about those who were in custody.

The law in regard to commitment to mental hospitals bears silent testimony to the fact that every precaution was taken to ensure that only those definitely in need of custody and restraint should enter the solemn portals of the asylum. Only in more recent times has the policy of "voluntary commitment" been in force; in consequence, the public reaction has been conditioned against mental hospitals.

With the development of medical knowledge, with the expansion of the field of psychiatry, with the clearer understanding of the physical and emotional factors that lie behind mental disease, the whole concept of administration of these great institutions has changed.

No longer is a good mental hospital a place of

custody only, but of active treatment, medical, surgical, psychiatric, with all the allied physical and occupational therapies that modern science has devised.

But the massive hospital building remains as does the high cyclone fence, the stately iron gateway and the guard at the gate, and these serve to perpetuate in the public mind the old conception, behind which was fear.

The spirit of the modern mental hospital must come out of the gate and into the community, interpreting to the community the change that has been wrought in our conception of mental disease and the methods of cure. Without this interpretation, much ground will be lost with the inevitable reduction in funds available for the program in these days of economic stress.

This danger is real and not theoretic, for the welfare institutions are among the largest spending agencies in government, second only to education or highways in most states. They, therefore, become the target for economy programs, which never take into consideration the fact that the net gain in mental hospital population each year, in our large industrial states, is sufficient to fill a new institution of moderate size; 690 net increase, for example, in New Jersey last year.

How, then, may a mental hospital establish public relations that will safeguard the professional and custodial work which it renders to its wards?

Two views of Marlboro State Hospital and, on the opposite page, the imposing entrance to Trenton State Hospital. Both institutions have modern plants.

The experience of New Jersey over a period of seventeen years provides some specific answers to this question. In 1918, the department of institutions and agencies was established by law with all charitable, eleemosynary, correctional and penal

institutions coordinated for purposes of administration under the state board of control.

This consolidation of public institutional and agency welfare activities under the administrative leadership of the commissioner of the department served to promote coordination of the entire institutional system; stimulated the development of uniform standards of administration; made possible comprehensive planning for future development of the institutional program; equalized budgets as between institutions based upon demonstrated needs, and also provided a spokesman for the institutional service as a whole, which has been of great value to the entire system.

Spokesmen for the Institution

While a centralized authority is of advantage to any public institutional system, the interpretation of the individual institution within the state system to its public is dependent upon a more intimate contact with the professional staff and with the local board of managers, who, as citizens, know intimately the problems and policies of the institution and are its authoritative spokesmen.

New Jersey, therefore, through its state board of control, its commissioner and its local boards of managers has an effective mechanism for safeguarding the interests, financial and professional, of its welfare institutions.

There remains, however, the education of the public as to the quality of the work done within the walls of the institution and outside the gates in the community itself, if the mental hospital is to be understood and appreciated by its constituents.

In accepting this educational responsibility, the state of New Jersey long ago recognized that its mental hospitals must be modernized physically; that they must be equipped with every up-to-date medical, surgical and laboratory appliance, and that the staff must be adequately compensated and suitably housed in order that they might be free to devote their best efforts to the treatment of the mentally ill and the education of the public.

This "interpretation" divides itself into several definite lines of endeavor:

1. *With the patient and his family.* While "the voluntary patient" is frequently a serious cause of anxiety to the hospital administrator, nevertheless, the successfully treated voluntary case becomes one of the most convincing interpreters of the hospital and its work.

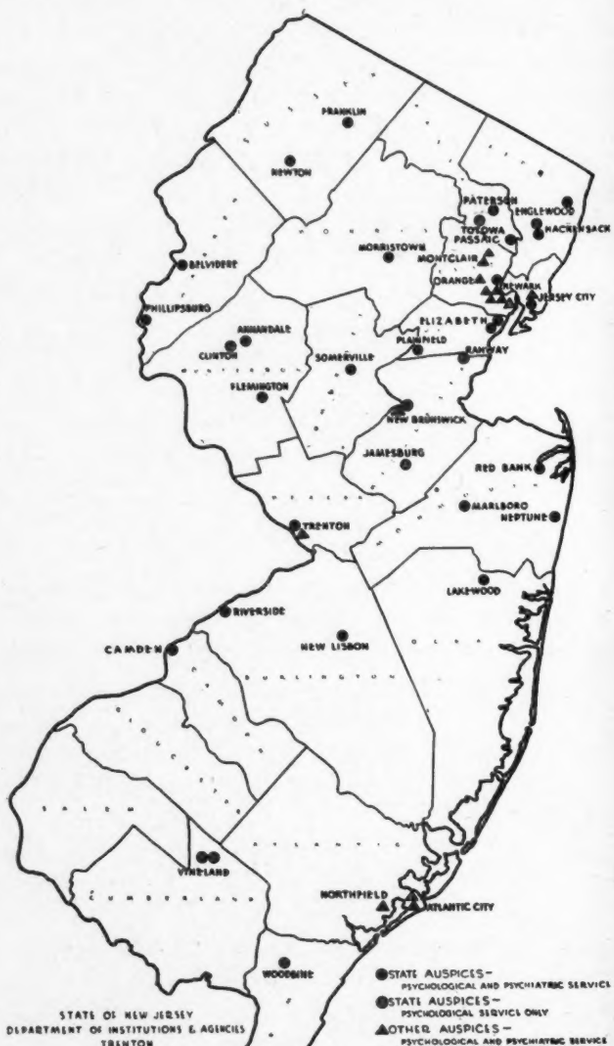
Visiting hours easily adjusted to the convenience of relatives and the accessibility of the staff to members of the family, for purpose of discussing the case and its problems, whether the case is legally committed or voluntary, affords a "public relations contact" invaluable to an institution.

These are accepted basic principles in the New Jersey system.

2. *With the physicians in the community.* All too often the physician who prepares commitment papers or the family physician loses track of the patient after the hospital gates close upon him. It is one of our objectives to make sure that these medical men, either through a transcript of the case record or personal conference, shall be thoroughly informed as to the findings, diagnosis, treatment and progress of the case.

In all our institutions from time to time clinics are held — medical, surgical, endocrine, psychiatric, dental—to which the medical profession in the surrounding territory is invited.

In certain of our institutions the regular meet-



A map showing the distribution of New Jersey's mental hygiene clinics, nine of which are under the auspices of Greystone Park State Hospital, seven under Trenton State Hospital, ten under Marlboro State Hospital, fourteen under other auspices and ten are clinics in the various state institutions.

ings of the county medical society are held, and in some instances the mental hospital has afforded the clinical material for medical extension courses offered under the auspices of Rutgers University to the county society.

The contacts established with the medical profession through community mental hygiene clinic service result in satisfactory understanding with an influential group of citizens, while membership in local and state medical societies and participation on their programs by members of the hospital staff ensures the recognition of the institution as one that is productive of original scientific material.

Making Friends With the Public

3. *With educational institutions.* The increasing desire of departments of psychology, sociology and penology to make available to their students first-hand contact with the mentally ill and defective affords to a mental hospital an invaluable opportunity for establishing relationships with the public, and this we in New Jersey eagerly grasp.

Groups of university students are welcomed; there is case conference discussion and institutional inspection under competent guidance. Nurses in training are received as affiliates in certain institutions, and public health nurses receive institute training. Members of the state hospital staff lecture on mental hygiene in training schools for nurses and at universities in the territory.

A limited number of young men and women have been received for informal "internships" on the level of attendants in our institutions, and their interest spreads understanding of mental hospital problems among their classmates when they return to college.

Through these many educational channels an influential body of public opinion is created, which is of great value to the institution as such and to the department as a whole.

4. *With civic organizations.* It is not enough that the patient and his family, that physicians, students and nurses should understand the purposes of mental hospitals and should approve their methods. It is essential that substantial lay men and women should become equally familiar with the mental hospital program and the needs that must be met.

To that end the mental hospitals of New Jersey encourage visitation by such organizations as the service clubs, the League of Women Voters, Federated Clubs and similar organizations, at which time after an informal luncheon, there is presented a formal program relating to some of the problems that are faced by the institution itself, resulting from the economic depression and its effect upon budgets, intake and parole; by the community and the social problems created by local economy measures unwisely conceived, and by the taxpayer who has the bill to pay, through welfare institutions, for the lack of preventive programs wisely administered.

These meetings of citizens in the institutions, the personal contact with staff and patients make for a friendly understanding attitude on the part of these visitors, which they carry with them into the community.

5. *With mental hygiene clinic service in the community.* Perhaps community clinic service extending out from the mental hospitals (and the parole service to a lesser degree) has done more than any one type of activity to create an appreciation of the fact that, after all, the mental hospital is not a thing apart, but is in very truth an intimate and necessary part of the community's equipment for its general social welfare.

Community clinic service staffed by competent psychiatrists, clinical psychologists, psychiatric social workers and clerical staff provides all the necessary parts of an educational and service mechanism. Through this service unit the man who walks in the street, the physician, the educator and the social worker become conscious of the interdependence of all phases of our community life, and especially aware of the basic importance of a mental hygiene program in all human welfare. In addition, the clients served by the clinic emphasize the effectiveness of this hospital extension service.

Trained Personnel and Money Needed

It is to be regretted that at the present time not only in New Jersey but throughout the country trained personnel in adequate numbers is not available to staff such clinical services, nor are funds made available to make such a program generally effective on a statewide basis.

The mental hospital of today cannot survive the economic depression and maintain a high level of professional excellence without the understanding support, moral and financial, of its various constituents.

To secure that support it must consciously interpret its objectives and its methods to its public through an educational program adapted to the intellectual grasp of the individuals and social groups that constitute its public.

Finally, if it is not to be overwhelmed by an ever increasing burden of the mentally ill, it must carry a preventive mental hygiene program out into the community through its clinical service.

What Others Are Doing

Flat Rate for Diagnosis

Hoping to stimulate the use of its diagnostic facilities and at the same time to gratify the desire of its staff men for such a service, Ravenswood Hospital, Chicago, recently put into effect a flat rate diagnostic service.

There are two of these services, the first providing up to three days' hospitalization and including all necessary x-ray and laboratory services indicated and ordered by the attending physician except radiologic and gastro-intestinal examinations; the second planned on a four-day basis, unlimited and all-inclusive.

Prices for the first service range as follows: for a bed priced at $3.50, $25; for one at $4, $26.50; at $4.50, $28; at $5, $29.50; at $7, $36; at $8, $39; at $10, $46. For the second they run for a bed priced at $3.50, $47.50; at $4, $49.50; at $4.50, $51.50; at $5, $53.50; at $7, $62; at $8, $66; at $10, $75.

"To what extent these rates will stimulate our diagnostic services remains to be seen," writes J. Dewey Lutes, superintendent. "They have been in effect but a short time. Theoretically the results should be satisfactory. It makes it possible for the physician to inform his patient exactly what the hospital bill will be when he enters for a complete diagnostic service so that the patient is neither irritated nor surprised when he pays the bill. Those whose duty it is to present the patient with the bill will say 'Amen' to this phase of the service."

College Courses at a Hospital for the Mentally Ill

A combination college and vocational school has grown up at Butler Hospital, an institution for the care of the mentally ill, at Providence, R. I. Instruction is offered in almost any subject desired, if it will build up confidence and ability in the patient, for the hospital recognizes the principle that learning should never cease.

"For people recovering from mental illness," writes Dr. Arthur H. Ruggles in the ninety-second annual report of the hospital, "instruction definitely identified with daily life may be a real aid to convalescence. In many cases, educational and vocational activities contribute so materially to enjoyment of life, sense of social security and opportunities for service that patients gradually lose their tendencies to depression and morbid ideas, and come to feel a stronger sense of life being worth while than they have ever known before.

"Although we recognize that the correction of any physical disorder and the straightening out of mental twists are our first and foremost functions, we nevertheless believe that our work is not complete until we have given our patients a greater degree of emotional control. . . ."

During the winter a series of lectures on art, science, travel and history are given by distinguished lecturers. Concerts, dramatic entertainments and motion pictures are also used as integral parts of the program to "save patients from or help them to regain what the author of the widely read and much discussed 'Asylum' gives as the cause of most mental illness—loss of control."

Hotel Is Used for Overflow Patients

Because many patients who are sent for treatment to the University Hospitals, Iowa City, Iowa, can be given care in the out-patient department and do not require constant bed service, arrangements have been made by the hospitals to house these patients in one of the hotels in Iowa City. This arrangement was originally effected in order to conserve hospital beds and to keep the beds of the hospital available for the heavy demand of bed cases.

In recent months, however, the occupancy in the hospital has become so high that the plan is even more advantageous as it permits the hospital to care for patients who would otherwise have to be refused because of lack of facilities. Most of the time recently this 900-bed institution has been filled practically to capacity.

In order to assist the hotel in keeping control of the hospital patients, a copy of the following regulations is given to every patient sent to the hotel:

"1. All patients shall register with the clerk upon arrival at the hotel.

"2. Patients will be required to be in the hotel not later than 10 p.m. after which time all must be in their rooms and observe strict quiet for the benefit of others.

"3. Patients desiring to be out of the hotel during the evening must sign the register at the desk before leaving the hotel and sign the register again as they return not later than 10 p.m.

"4. Any misconduct on the part of patients or violation of these regulations will be reported to the hospital authorities by hotel attendants.

"The hotel and hospital managements solicit any reports from patients which may aid in keeping the hotel service at reasonable standards."

Obstetric patients and patients on crutches or with physical handicaps are not referred to the hotel as the hospital does not wish to house physically handicapped patients in a non-fireproof building.

Flat Rate Applied to Surgical Cases

A flat rate for maternity cases has proved popular in many institutions. This same idea has been carried even further in the Community Hospital, New York City, and applied to surgical operations. For patients whose financial position warrants it, a flat rate of $110 has been established for major surgical procedures including 10 days of hospital care, also doctor's fee. The hospital collects the entire amount, allocating $60 to its own account and turning over $50 to the doctor in charge. The plan is working out well, according to Katherine J. Steele, superintendent of the institution. The doctors under this administrative service are assured some recompense, at least, for their services, which only too often might otherwise produce no revenue.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

Dovetailing Health Work

A closer tie-up between hospitals and health centers is urged by this author who sees an opportunity for decreasing duplication of effort and broadening the hospital's usefulness

By CHARLES F. WILINSKY, M.D.
Director, Beth Israel Hospital, Boston

THE committee on public health relations of the American Hospital Association called attention several years ago in its annual report to the fact that few nationally recognized health centers are housed in hospitals, and that the establishment of health centers could rarely be traced to hospital workers. Health centers had been developed as a rule, the report stated, by health departments, frequently in cooperation with large philanthropic foundations. This was influenced by the availability of tax funds for buildings and equipment and generous grants from foundations.

The report emphasized the lack of such financial resources in small communities, and stressed the possibility of utilizing hospitals for health center objectives and programs.

The health center movement is of comparatively recent origin. In its inception its motivating principle was the bringing together under one roof of agencies engaged in public health services and, when possible, of agencies carrying on welfare activities. The sponsors of this movement, which originally took root in only a few places in the United States, believed that the bringing together under one roof of groups engaged in common effort would result in better coordination and would tend to eliminate the duplication and waste found when a number of agencies carry on activities from different headquarters and without coordination of effort.

It was recognized that one building, serving as physical headquarters for agencies engaged in community health work for a definite unit of the population, would minimize confusion and duplication. Furthermore, it was evident that the efficiency of the different agencies would be improved because of the unifying influences of a common meeting place and because of the opportunities for daily, intimate discussion of mutual problems. The need for the coordination of health and welfare services is particularly striking because few communities enjoy a complete program maintained exclusively under either municipal or private auspices. The prevalent picture is that of a number of functioning agencies, official and voluntary in their support, maintaining various essential activities. For example, it is not unusual to find a prenatal clinic under the auspices of one agency, baby clinics under another and tuberculosis clinics, visiting bedside nursing service, venereal disease clinics under the direction of others, some official, some voluntary and some receiving support from both sources.

Complications arise from duplications which come about because similar public health programs are being maintained by more than one agency in a community. Another problem is the gap due to the absence of an essential service. It is in the development of better understanding, in the coordination of effort, in the avoidance of gaps and the prevention of duplication that the health center has been most effective.

Confusion of Terms Is Misleading

We find the term "health center" frequently used in connection with maintenance of one distinct service, such as "baby health center," "tuberculosis health center," "child guidance health center." A survey of health centers in connection with the White House Conference indicated that several thousand so-called child health centers existed, all of which gave only limited service. These should be distinguished from health centers which offer a complete program of preventive, clinical services and which usually house a majority of the community agencies engaged in health relief work.

Boston, New York City, Buffalo, Wilkes-Barre, Pa., Los Angeles County, California, are some of the communities in which are found striking ex-

amples of the type of health center conducting a varied program and presenting the advantages of coordinated effort.

In Boston a health center known as the Blossom Street Health Unit was founded twenty years ago. Its objective from the beginning was the carrying out of the principles defined above. A number of years later the bequest of a generous citizen of Boston, George Robert White, enabled the health unit movement to expand, and through the expenditure of approximately three millions of dollars seven health units were built and equipped. These centers are in the congested sections of the city and maintain an extensive program of preventive services, supplemented materially by the activities of the official and voluntary relief agencies. The units serve as the physical headquarters of all approved agencies concerned with the protection of public health and the amelioration of human suffering.

A Health Chain Established

The American Red Cross, which shortly after the World War was an important factor in the furtherance of the health center movement, financed the development of the East Harlem Health Center in New York City. The influence of the excellent work carried on at East Harlem did much to promote health center organization in other sections of New York City. While the East Harlem Health Center, the Bellevue Yorkville Health Center, the Judson Health Center and the Bowling Green Health Center were supported originally by private funds, some have been taken over by the New York Department of Health. Federal funds have also been allocated within a comparatively recent period for the establishment of a chain of health centers in various parts of New York City, to be maintained by the city health department.

There was established over a period of years a series of centers in various sections of Los Angeles County, California, which offered a combination of both preventive service and treatment, including, moreover, a limited number of hospital beds for what may be termed emergency service. This was an excellent demonstration of decentralized health services on a county basis.

A chain of health centers, providing preventive and, in a measure, curative services, was set up in Buffalo early in the history of the health center movement through the joint efforts of the department of health and the Buffalo City Hospital.

Further examples could be cited illustrating the advantages of coordinated health and welfare services as carried on in many communities in the United States. The programs maintained by these centers may be said to vary according to the particular needs of the area and people they serve. Some offer preventive services only; others, curative; still others, a combination of both, depending upon local conditions and requirements. Some health centers receive financial support from tax funds, others, from voluntary sources, some, from both sources.

Health centers have been classified as centralized and decentralized in type. Those in Wilkes-Barre, Pa., and Schenectady, N. Y., may be considered as examples of the centralized type of health center serving an entire community through the medium of the agencies housed under one roof. In these cases the health center functions as the headquarters of the department of health of the city and of other essential community health agencies.

On the other hand, Boston, New York City, Buffalo, St. Louis, and other cities have a chain of health centers, located where most needed, which offer community service on a decentralized basis. The variance of programs is well illustrated by the program of the already mentioned Los Angeles County health centers which are intended to provide not only preventive service but a combination of surgical and medical service with emergency beds and laboratory work. The program of the Boston Health Units, on the other hand, includes prenatal care, infant and preschool clinics, dental service, nutrition clinics, a mental hygiene clinic, tuberculosis service, bedside nursing care, mothers' classes, solariums for pretuberculous children, welfare service and similar preventive work.

Hospitals Playing Their Part

The committee on public health relations in urging that more hospitals be developed as health centers indeed charted the way for a wise journey, for it is undeniable that many communities have not the financial resources to build and equip health centers. Moreover, it is true that substantial expenditures would not be justifiable in many communities where well functioning hospitals exist and around which it would be logical to build the complete community program for preventive and curative medicine.

It is important to call attention to the fact that hospitals are carrying on a number of activities of significant public health value, particularly in their out-patient departments and dispensaries. The treatment of contagious diseases, the isolation of infected persons, the diagnosis and treatment of gonorrhea and syphilis, tuberculosis, diabetes, heart disease, cancer, the care of the crip-

ple and dental care are but some of the services offered by hospitals and out-patient departments, which are intimately related to public health. In the food clinic, in the education of the individual in the principles of personal hygiene, in occupational adjustments, in the training of personnel, in reaching out to the community itself with a health message, hospitals serve in many communities in the capacity of health centers.

In maintaining the above services, hospitals and clinics perform important functions which play a significant part in the conservation of health, in shortening the duration of illness, and in lengthening life. To these services may be added in communities where health departments are not already conducting them, such valuable public health activities as prenatal and postnatal care, well baby and preschool clinics, including facilities for vaccination against smallpox and immunization against diphtheria. Serious consideration should be given to the maintenance of child guidance mental hygiene clinics because of the recognition of the value of this type of service for the prevention of various psychiatric conditions.

In attempting to link hospitals with health centers, one must emphasize the need for cooperation between local departments of health and the hospitals of the communities they serve. While in large cities budgets may provide for the maintenance of headquarters by health departments for clinical activities, in small communities it will be frequently found feasible to develop a relationship whereby a good local hospital may serve as headquarters for the carrying on of clinical services under health department auspices.

In other instances it may be practical for the health department to give financial assistance to the hospital for the maintenance of prophylactic services which are in the ordinary course of events the responsibility of the official health agency. In still other instances the hospital may find itself obliged to meet the preventive needs of the community by maintaining essential prophylactic services. Individual local conditions must be considered in deciding what method will best serve the particular community under consideration.

Start Your Own Credit File

Human nature being what it is, most hospitals have adopted a policy of demanding payment in advance for hospital service. This policy is not always a wise one, particularly in communities where the clientele return to the hospital again and again. But the hospitals in such communities must protect their interests. One of the steps in that direction is an adequate credit file.

A credit file is nothing more or less than data, largely financial, of individuals showing not only the ability to pay bills, but also the degree of inclination to do so. It represents the financial integrity of the individual. One can soon build a substantial credit file by beginning with today's patients and preparing a card for each similar to the one used by many hospitals as a tickler. This card should carry the name of the head of the family, as well as the name of the patient; the address and telephone number of both business and residence; the name of the doctor; type of accommodation with rate for same, and total amount of the bill. When the bill is paid, the date should be entered, and, if paid by check, the name of the bank on which the check is drawn. The next time a member of the family is admitted, the additional information should be added.

If, for any reason, it seems advisable to clear through the local credit bureau, the information secured and its source should be added. Newspaper notices, such as deaths, notices of bankruptcy or business promotions should be attached permanently to the card. Note should be made of a hospital contributor, giving both date and amount of contribution. If the account proves to be uncollectible, the card should be stamped "bad account" in red, giving the date.

The cards should be filed alphabetically with sufficient subdivisions to facilitate the location of a card, for the use of the file is dependent upon the ease with which the desired card is found.

The practice should be established of going to the file whenever a reservation is made in order to see if a card is available. If there is a card, one can more easily decide whether it is good policy to collect in advance or bill on discharge.—*Ada Belle McCleery, Evanston Hospital, Evanston, Ill.*

When the Budget Runs Out

The frequency with which hospital administrators are compelled to disapprove reasonable requests from members of the medical staff for funds to cover extra-budgetary purposes is inversely proportional to the extra-budgetary funds available. Medical luxuries, or, at least, those that are not absolute necessities, if provided, sometimes give character and personality to the hospital and often achieve worthy ends.

Most of the funds that are normally considered extra-budgetary are restricted for research purposes and not available for many worthy projects no matter how inexpensive they may be, and one hesitates to assign budgetary funds in times like these except for necessities.

It is suggested therefore that a miscellaneous fund be established into which could be thrown donations of a minor character. This would be a pocket money arrangement for the administrator whereby he could hand out small change here and there and produce returns out of all proportions to the amount.—*Morris Hinenburg, M.D., Jewish Hospital, Brooklyn, N. Y.*

The A. H. A. Convention Program

General Business Session

Monday, 2:00 p.m.

Chairman: Robin C. Buerki, M.D., president.

Presentation of Committee reports.

President's Session

Monday, 8:00 p.m.

Addresses of Welcome.

Address: Robin C. Buerki, M.D.

Address: Lawrence Davis, president of Hospital Exhibitors' Association.

Conferring of National Hospital Day Award by Albert G. Hahn, Deaconess Hospital, Evansville, Ind., chairman, National Hospital Day Committee.

Departmental Demonstrations

Tuesday, 9:00 a.m.

Hospital Accounting, Lee S. Lanpher, Evangelical Lutheran Hospital, Cleveland. Hospital Service Plans, John A. McNamara, Cleveland Hospital Service Association.

Construction Section

Tuesday, 9:00 a. m.

Chairman: Lewis E. Jarrett, M.D., Medical College of Virginia, hospital division, Richmond.

Report: Air Conditioning, C. W. Munger, M.D., Grasslands Hospital, Valhalla, N. Y.

Symposium on Paging Systems: (1) Loud Speaking, G. Rush Willett, G. R. Willett and Company, Chicago; (2) Ticker System, C. S. Lentz, M.D., University of Virginia Hospital, Charlottesville; (3) Light System, Charles W. Myers, M.D., Indianapolis City Hospital, Indianapolis.

Discussion: John Gorrell, M.D., Falk Clinic, University of Pittsburgh.

Report: Hospital Planning and Equipment, Charles F. Neergaard, hospital consultant, New York City.

Discussion: James Govan, Govan, Ferguson and Lindsay, architects, Toronto, Ont.

Symposium on Floor Covering Materials: (1) Maintenance and Renovating Original Floor, M. Haskins Coleman, Richmond Hospital Service Association, Richmond, Va.; (2) Mastic or Asphalt Tile, Lucius R. Wilson, M.D., John Sealy Hospital, Galveston, Tex.; (3) Linoleum, George U. Wood, Peralta Hospital, Oakland, Calif.; (4) Rubber Tile, William H. Walsh, M.D., hospital consultant, Chicago.

Tuberculosis Section

Tuesday, 9:00 a. m.

Chairman: H. A. Pattison, M.D., Potts Memorial Hospital, Livingston, N. Y.

Address: Surgical Management of Pulmonary Tuberculosis, E. J. O'Brien, M.D., Detroit.

Discussion (Illustrated): S. O. Freedlander, M.D., Cleveland.

Address: Planned Health Service for Employees in Tuberculosis Sanatoriums, E. S. Mariette, M.D., Minneapolis.

Discussion: Clarence E. Hyde, M.D., East Akron, Ohio.

Address: The Value of Physical Environment in Handling Tuberculous Patients, C. A. Mills, M.D., Cincinnati.

Discussion: Ernest E. Bishop, M.D., Cincinnati.

Tuesday, 2:00 p. m.

Address: When Should Rehabilitation of the Tuberculous Begin? (Illustrated), Holland Hudson, Cincinnati.

Discussion: Glenford L. Bellis, M.D., Wauwatosa, Wis.

Address: Post-Sanatorium Care of the Tuberculous (Illustrated), Edward Hochhauser, New York City.

Discussion: H. A. Pattison, M.D., Livingston, N. Y.

Address: The Value of the Library in the Sanatorium, Bernice E. Schildwachter, Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill.

Discussion.

Election of Section Officers.

Dietetic Section

Tuesday, 9:00 a.m.

Chairman: Kate Daum, Ph.D., University of Iowa Hospitals.

Address: The Use of Vitamin Concentrates in the Food for the General Patient and the Personnel.

Address: Wholesale Production of Certain Foods by the Hospital—Bread, Ice Cream, Milk.

Address: Use of Silence Material, Air Conditioning, and Forced Ventilation in the Hospital Dietary Department.

Address: Cost of Food for Personnel, Including Standards of Purchase and Preparation and Kinds of Service.

Discussion of certain problems connected with food service: (1) meal hours in the hospital; (2) night supper, time and character; (3) responsibility for time of service and kinds of fluids and supplementary nourishments; (4) methods and cost of dispensing therapeutic diets.

Small Hospital Section

Tuesday, 2:00 p. m.

Chairman: James A. Hamilton, City Hospital, Cleveland.

Address: Value of a Commercial Representative to the Small Hospital Administrator, Jack Alexander, Tulsa, Okla., and Edgar Blake, Jr., Methodist Episcopal Hospital, Gary, Ind.

Address: The Small Hospital in a Rural Community, Olive J. Brown, De Ette Harrison Detwiler Memorial Hospital, Wauseon, Ohio.

Discussion: Albert S. Buchanan, M.D., Cora Donnell Hospital, Prescott, Ark.

Address: How to Improve Public Interpretation of Hospital Standardization, Mary L. Whittaker, Margaret Pillsbury General Hospital, Concord, N. H.

Discussion: Miriam Curtis, Cooley-Dickinson Hospital, Northampton, Mass.

Round Table: G. Harvey Agnew, M.D., department of hospital service, Canadian Medical Association, Toronto, leader.

Election of Section Officers.

Out-Patient Section

Tuesday, 2:00 p.m.

Chairman: E. L. Harmon, M.D., University of Cleveland Hospitals.

Report of Out-Patient Committee, Frederick MacCurdy, M.D., Vanderbilt Clinic, New York City, chairman.

Trustees' Round Table

Tuesday, 2:00 and 8:00 p.m.

Leader: Ingersoll Bowditch, trustee, Faulkner Hospital, Jamaica Plain, Mass.

Subjects: Administration; Legislation; Public Relations, and Finance.

Departmental Demonstrations

Wednesday, 9:00 a.m.

Surgical Technique, G. E. Follansbee, M.D., Cleveland. Obstetrical Technique, presented by Ohio Hospital Obstetrics Society. C. S. Woods, M.D., St. Luke's Hospital, Cleveland, chairman.

Administration Section

Wednesday, 9:00 a. m.

Chairman: Allan Craig, M.D., Charlotte Hungerford Hospital, Torrington, Conn.

Report of the Committee on Simplification and Standardization of Hospital Furnishings, Supplies and Equipment, Malcolm T. MacEachern, M.D., chairman.

Address: Hospital Intangibles, Joseph C. Doane, M.D., Jewish Hospital, Philadelphia, and editor, The MODERN HOSPITAL.

Address: Relations of Administration to Medical Progress in Hospitals, George Crile, M.D., Cleveland Clinic Hospital, Cleveland.

Address: Looking Ahead Through the Nursing Curriculum, Effie Taylor, dean, Yale School of Nursing, New Haven, Conn.

Address: How I Would Conduct My Institutional Purchasing If I Had a Free Hand, George Stephens, M.D.,

September 28—October 2

R. C. Buerki, M.D.

C. W. Munger, M.D.

Winnipeg General Hospital, Winnipeg, Manitoba.

Children's Hospital Section

Wednesday, 9:00 a. m.

Chairman: Margaret Rogers, Children's Hospital, Detroit.

Address: The Relation of the Hospital Residency to Graduate Education in Pediatrics, Borden Veeder, M.D., chairman, American Board of Pediatrics and chairman, committee on medical education, American Academy of Pediatrics.

Address: Opportunities for Parent Education in the Children's Hospital and Means of Developing Them, Winifred Rand, Merrill Palmer School, Detroit.

Address: The Human Side of the Children's Hospital, Elizabeth Lee Vincent, M.D., Merrill Palmer School, Detroit.

Panel on Children's Hospital Problems: Mabel Binner, Children's Memorial Hospital, Chicago; Gerald Williams, M.D., Children's Hospital of Winnipeg, Winnipeg, Man.; Robert Witham, Children's Hospital, Denver; Winifred Culbertson, Children's Convalescent Home, Cincinnati; Mrs. Gertrude R. Folendorf, Shriners' Hospital for Crippled Children, San Francisco.

Small Hospital Round Table

Wednesday, 9:00 a.m.

Leader: James A. Hamilton, City Hospital, Cleveland, assisted by G. Harvey Agnew, M.D., secretary, department of hospital service, Canadian Medical Association, and Graham L. Davis, Duke Foundation, Charlotte, N. C.

General Session

Wednesday, 2:00 p.m.

Presentation of Committee Reports.

Hospital Libraries Round Table

Wednesday, 2:00 p.m.

Chairman: Elizabeth Reed, McLean Hospital, Waverley, Mass.

Address: Costs and Benefits of Hospital Library Service, Herman Hensel, Presbyterian Hospital, Chicago.

Address: Hospital Library Service in Rochester, N. Y., Julia L. Sauer, Public Library, Rochester, N. Y.

Annual Banquet and Ball

Wednesday, 7:00 p. m., Statler Hotel

Presiding: R. C. Buerki, M.D.

Address: Hon. Newton D. Baker, Cleveland.

Departmental Demonstrations

Thursday, 9:00 a.m.

Various Kinds and Cuts of Meat, Mr. Hartzel, Swift & Co., Chicago.

Canned Foods, Howard A. Orr, National Canners' Association.

Therapeutic Diet, H. L. Rockwood, M.D., Mount Sinai Hospital, Cleveland.

Section on Mechanical Divisions of Hospital Operation

Thursday, 9:00 a. m.

Chairman: S. Frank Roach, Jersey City Medical Center.

Address: Care and Preservation of Portable Equipment in the Hospital, Donald C. Smelzer, M.D., Graduate Hospital of the University of Pennsylvania, Philadelphia.

Address: The Result of Survey Covering the Hospital Fire Hazards, William S. Outwater, director, School for Fire Instruction, and battalion chief, Jersey City, N. J.

Address: Weighing the Hospital Power Plant Problem to Provide Efficiency, Philip W. Swain, M.E., editor, *Power*.

Address: The Administrative Viewpoint of the Mechanical Divisions of Hospital Operation, Malcolm T. MacEachern, M.D., department of hospital activities, American College of Surgeons.

Social Service Section

Thursday, 9:00 a.m.

Chairman: Mary Wysor Keefer, University of Chicago Clinics.

Presiding: Dr. Malcolm T. MacEachern.

Address: The Importance of Established Standards in a Hospital Social Service Department, Mrs. Charles W. Webb, social service department, University of Cleveland Hospitals.

Address: Their Significance to the Hospital, S. S. Goldwater, M.D., Department of Hospitals, New York.

Address: Their Contribution to the Community Through Hospital Councils, Mrs. Mary Hicks Bachmeyer, Chicago.

Thursday, 2:00 p.m.

Address: Social Security for Crippled Children, Dr. Martha M. Eliot, Washington, D. C.

Address: Important Values in the Physical Care of Crippled Children.

Address: Medical Social Aspects of the Problems of the Crippled Child.

Nursing Section

Thursday, 2:00 p. m.

Chairman: Helen Teal, R.N., Indiana State Nurses' Association.

Symposium on Pocketbooks and Good Nursing: (1) Essentials of Good Nursing Care, Claude W. Munger, M.D., president-elect, American Hospital Association; (2) Can Hospitals Afford to Meet These Standards? (a) The Hospital With a Small School and a Large Graduate Staff, Macie N. Knapp, Brokaw Hospital, Normal, Ill., (b) The Hospital With a Large School and a Small Graduate Staff, H. L. Rockwood, M.D., Mount Sinai Hospital, Cleveland, (c) The Small Hospital With an All-Graduate Staff, Gladys Brandt, Cass County Hospital, Logansport, Ind., (d) The Large Hospital With an All-Graduate Staff, E. Charlotte Waddell, Woman's Hospital, Detroit; (3) Are These Standards Which Can Be Applied in Only a Few Hospitals and in Certain Sections? A. M. Calvin, chairman, Hospital Council, St. Paul, and Sister M. Laurentine, R.N., chairman, eight-hour duty committee, Pennsylvania State Nurses' Association; (4) Shall We Help Our Nurses Give Better Care? R. C. Buerki, M.D.

Report: Incomes, Salaries, and Employment Conditions Affecting Nurses Employed in Institutions, Mrs. Elizabeth August, executive secretary, Ohio State Nurses' Association.

Symposium

Thursday, 2:00 p.m.

Group Hospitalization.

Leader: Rufus Rorem, Ph.D., Julius Rosenwald Fund.

Public Hospital Section

Thursday, 8:00 p. m.

Chairman: D. L. Richardson, M.D., Charles V. Chapin Hospital, Providence, R. I.

Address: Psychiatric Service in the General Hospital, Samuel W. Hamilton, M.D., division on hospital service, National Committee for Mental Hygiene.

Discussion: George O'Hanlan, M.D., Jersey City Medical Center, Jersey City, N. J.; Lucius R. Wilson, M.D., John Sealy Hospital, Galveston, Tex.; L. E. Hanisch, M.D., Lutheran Hospital, Omaha, Neb.

Address: Los Angeles County's New 2,500-Bed Hospital Building (Illustrated), G. W. Olson, Los Angeles County General Hospital.

Discussion: S. S. Goldwater, M.D., commissioner of hospitals, New York.

Address: Politics in Public Hospitals, Russell H. Oppenheimer, M.D., Emory University Hospital, Emory University, Ga.

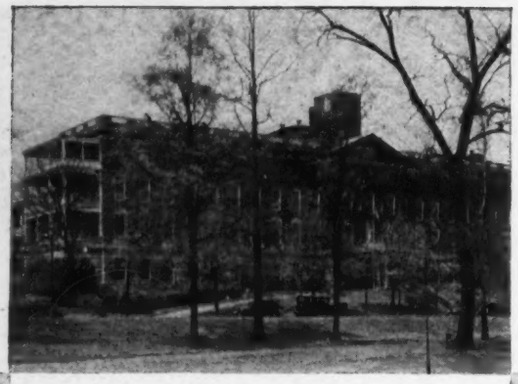
Closing Business Session

Friday, 9:00 a.m.

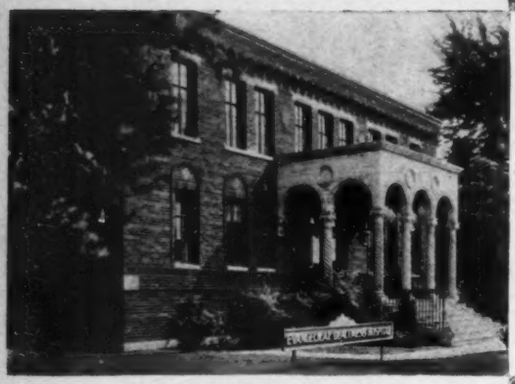
Presiding: R. C. Buerki, M.D.

Induction of New Officers. Unfinished Business. New Business.

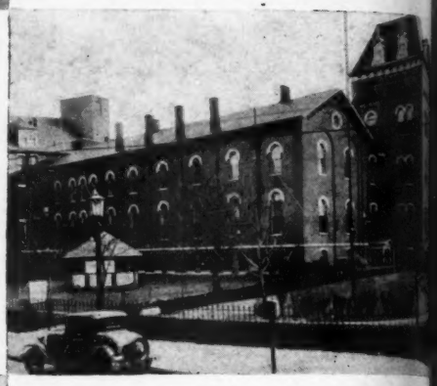
Cleveland



Mount Sinai Hospital (right) enjoys an excellent reputation and its work is nonsectarian. It operates a large out-patient department, the clinics of which are held in the morning hours.



St. Vincent Charity Hospital (right) bears the brunt of accident and emergency cases in the downtown area. Its accident room, recently remodeled, is noteworthy for its efficiency and completeness.

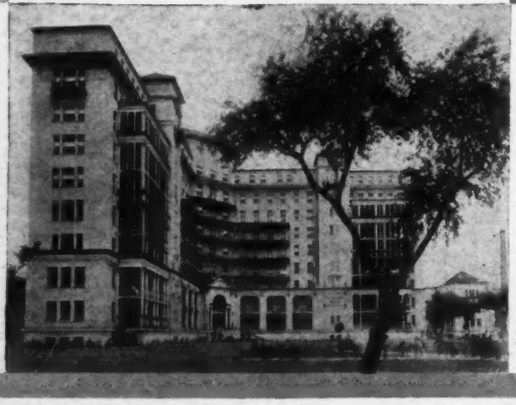


Evangelical Deaconess Hospital (above) serves a large residential area. The present building was completed in 1928, and its facilities are thoroughly modern. The bed capacity is 144.

Woman's Hospital (left) was founded by a small group of homeopathic women physicians. Now it is a general hospital with a staff of men and women and with patients of both sexes.

City Hospital, the medical and surgical building of which is shown below, has many units, the newest of which is its tuberculosis division. This hospital has the only fever therapy department in town.

Fairview Park Hospital (above), formerly the German Hospital, serves a thickly populated district on the Near West Side. It recently completed a campaign for expansion funds.



Grace Hospital (above) is a general hospital, nonsectarian in nature. The larger part of its work is surgical, and it serves a densely populated area southwest of the downtown section.

Hospitals and Hospitality

By E. L. HARMON, M.D.
Assistant Director, University Hospitals, Cleveland

CLEVELAND, through years of effort on the part of outstanding community leaders and members of the medical profession, is hospital-minded. It takes pride in its hospital facilities, most of which are housed in modern buildings.

Nineteen institutions in the city are members of the American Hospital Association. For the benefit of convention visitors who may wish to visit one or more of these hospitals the following brief descriptions are submitted. They are arranged in alphabetical order.

Charity Hospital: Charity Hospital (St. Vincent Charity Hospital), located at East 22nd Street and Central Avenue, is now familiarly known as Cleveland's only downtown hospital. It is a general hospital with a rated total bed capacity of 295, of which number approximately 230 are in operation at present.

The hospital is a private, nonprofit corporation operated under the auspices of the Sisters of Charity of St. Augustine. It has the distinction of having been founded in 1852 as the first Cleveland hospital. During the Civil War the building was expanded and the property of the present location secured.

Located just outside the downtown business area and in the midst of a populous section where thousands of the poorer classes live, Charity has the brunt of the burden of caring for accident and emergency cases occurring in the downtown area. The accident room has recently been remodeled and is noted for its efficiency and completeness.

A unique feature in the operation of the institution is a central dressing room in which all instruments, solutions, dressings and apparatus are stored, and these are available on a moment's notice for bedside care of patients anywhere within the hospital. Completeness of the trays and promptness of service are particular features of this service.

City Hospital: The Cleveland City Hospital, a municipally owned and operated institution, located in the southwestern section of the city, at 3395 Scranton Road, has a capacity of 1,460 beds and 50 bassinets. It is a general hospital, having separate units for contagious, psychopathic and tuberculous cases.

The hospital grounds cover twenty-seven and a half acres and the buildings in use at present, all constructed since 1922, represent an investment of about $8,000,000.

The newest development at City Hospital is the tuberculosis division, Lowman Memorial Pavilion, with a capacity of 350 beds in one, two and three-bed units. Distinctive in this unit are its U-shape for east, west or south exposure of nearly all patients, deck space on the roof for sun and air baths, carbon arc solarium treating twenty patients simultaneously, a one-unit radio receiving equipment combined with a public address system, and a twenty-six bed unit of single rooms for the

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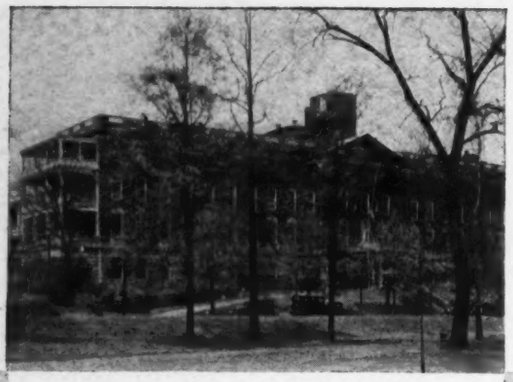
Cleveland



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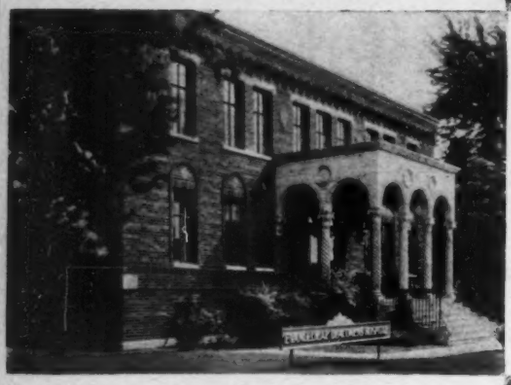

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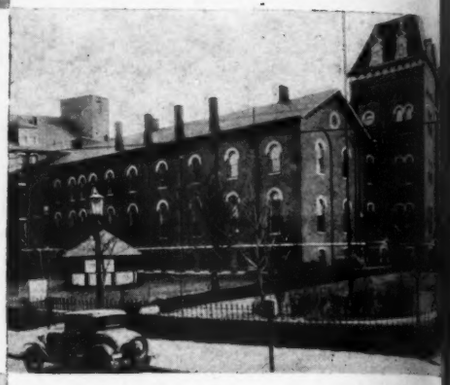

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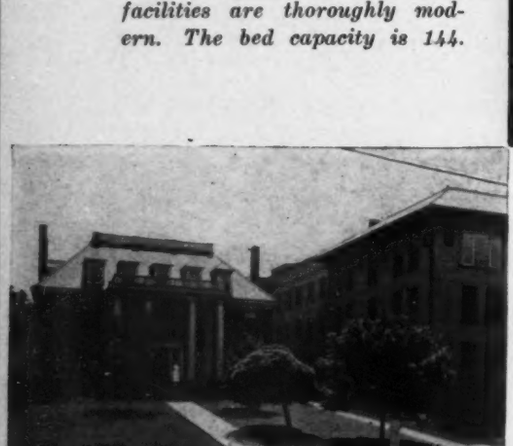

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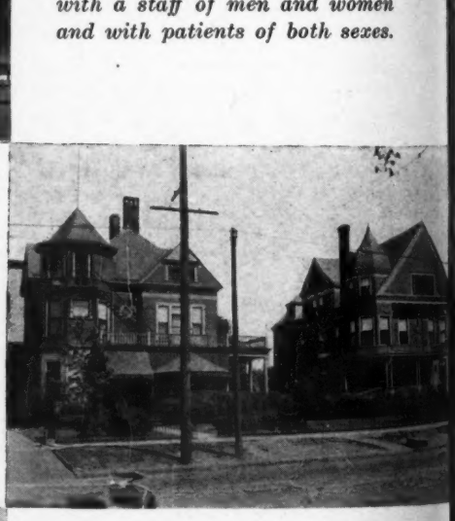

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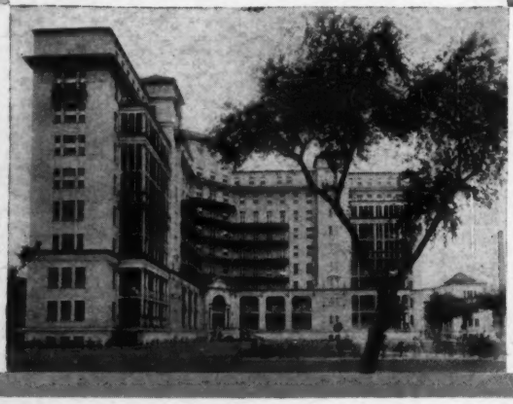

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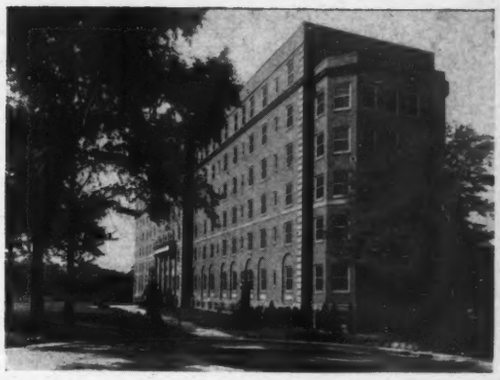

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postoperative care of surgical tuberculosis cases.

The x-ray department has recently been modernized to provide a complete diagnostic and therapeutic service with new shockproof equipment and up-to-date accessories.

The institution boasts the only fever therapy department in Cleveland. Three cabinets for the induction of artificial therapeutic fever are used for the treatment of arthritis, gonorrhea and its complications, certain diseases of the central nervous system and other conditions inflammatory in nature. The department is most interesting for observation in the morning while patients are undergoing treatment.

The contagious unit comprises seven wards with a capacity of 200 beds. The psychopathic unit serves as a detention hospital for all cases of acute organic brain disease and psychoses of Cuyahoga County. It has well equipped occupational and physical therapy departments.

The hospital is affiliated with Western Reserve University as a teaching unit of the school of medicine. The chiefs of staff are appointed through nomination by the university and hold professorial rank in the university.

Metabolic Dining Room Is Feature

The Cleveland Clinic Hospital: This hospital was established three years after the opening of the Cleveland Clinic, owned by the Cleveland Clinic Foundation, incorporated in 1921.

The first unit of the hospital was opened June 14, 1924. Later the building was extended, being completed in 1929 with a capacity of 229 beds. Four floors of the seven-story structure are entirely given over to patients. The seventh floor contains the surgery, pathologic department, clinical laboratories and equipment room.

A special feature of the metabolic department consists of the metabolic dining room for both in- and out-patients in which are provided specially prescribed menus. A dietitian is in constant attendance to instruct patients.

The hospital building is modern, fireproof and long and narrow in construction. The main entrance of the hospital is on East 90th Street between Euclid and Carnegie Avenues. The hospital building extends through to East 93rd Street. It offers many other features of interest to hospital people.

Emergency Clinic: The Emergency Clinic is located at 928 East 152nd Street just north of St. Clair Avenue. The present building, constructed in 1927, is in the center of a large industrial area, and thus tends to attract all types of accident cases. It is equipped as a small general hospital with a capacity of from 25 to 30 beds.

Evangelical Deaconess Hospital: This hospital, owned and operated by the Evangelical Deaconess Society of Cleveland, is located in the southwest section of the city at 4229 Pearl Road. It is a general hospital with a bed capacity of 144, including 35 obstetrical beds. The present building was completed in 1928, and with new and up-to-date facilities serves a large residential area. It has earned a definite place among the outstanding hospitals of Cleveland.

Evangelical Lutheran Hospital: Lutheran Hospital, located on Cleveland's near west side, at 2609 Franklin Boulevard, is approximately one mile from the Public Square. It is owned and operated by the Evangelical Lutheran Hospital Association, representing twenty-three Lutheran churches of the Missouri Synod of Cleveland and vicinity.

The present building was erected in 1922 on the site of the former home of Senator Mark A. Hanna. In 1928 additional adjacent property was acquired for purposes of further possible expansion.

The hospital is a general hospital of 111 adult beds and 31 bassinets, with adequate clinical pathologic laboratories, x-ray, dietary and other services.

Fairview Park Hospital: This hospital operated under the auspices of a corporation known as the German Hospital d/b/a/ Fairview Park Hospital is located at 3305 Franklin Avenue, also on the near west side of Cleveland.

The institution has 113 beds, of which 18 are bassinets. It is a general hospital, the work of which is approximately 55 per cent surgical, 10 per cent medical and 35 per cent obstetric.

The hospital has an active out-patient department, the demands for which are constantly increasing because of the location of the institution in a thickly populated area.

Recently a successful campaign was completed to raise funds for further expansion.

Glenville Is Private Institution

The Glenville Hospital: This hospital, located at 701 Parkwood Drive, in the northeastern section of the city, is owned and operated by the Parkwood Hospital Association as a private, nonprofit institution, with a bed capacity of 109, of which 21 are bassinets. In 1933 a new wing was erected providing additional beds.

The institution was founded in 1907, and occupies an important place in the community which it serves.

Grace Hospital: Grace Hospital, a nonsectarian institution, was founded in 1910 by a group of physicians who incorporated under the name of

TWENTY HOSPITALS THAT WILL WELCOME VISITS FROM CONVENTION DELEGATES

Name	*Location*	*Executive Officer*	*Bed Capacity*
Charity	East 22nd Street and Central Avenue	Sister M. Brigid	295
City	3395 Scranton Road	James A. Hamilton	1510
Cleveland Clinic	2045 East 90th Street	Abbie I. Porter	229
Emergency Clinic	928 East 152nd Street	Mrs. Olive S. Hanson	30
Evangelical Deaconess	4229 Pearl Road	A. A. Kitterer	144
Evangelical Lutheran	2609 Franklin Blvd.	Lee S. Lanpher	142
Fairview Park	3305 Franklin Avenue	Philip Vollmer, Jr.	113
Glenville	701 Parkwood Drive	Mrs. Julia M. White	109
Grace	2307 West 14th Street	Alice E. Graham	32
Huron Road	Terrace Road and Belmore Avenue, East Cleveland	R. G. Bodwell	202
Mount Sinai	1800 East 105th Street	Dr. H. L. Rockwood	270
Polyclinic	6606 Carnegie Avenue	Dr. A. F. Spurney	105
St. Alexis	5163 Broadway Avenue	Sister M. Edigna	220
St. Ann's	3409 Woodland Avenue	Sister M. Amadeus	118
St. John's	7911 Detroit Avenue	Sister M. Carmelita	211
St. Luke's	11311 Shaker Blvd., Shaker Heights	Dr. C. S. Woods	392
Sunny Acres (Tuberculosis)	Warrensville	Dr. R. H. Browning	431
University	2065 Adelbert Road	Dr. R. H. Bishop	934
Windsor	4415 Chester Avenue, Cleveland, and Chagrin Falls	Herbert A. Sihler	110
Woman's	1946 East 101st Street	Wilda M. Hornberger	127

Physicians Hospital Association. It is a general hospital with a bed capacity of 32. The majority of the work of the institution is surgical. It is located at 2307 West 14th Street in a thickly populated area south and west of the downtown section of Cleveland.

Semiprivate Rooms Are Rule

Huron Road Hospital: This institution, occupying a new building at Terrace Road and Belmore Avenue, East Cleveland, just off Euclid Avenue, the main thoroughfare to the east, is operated under the auspices of the Cleveland Homeopathic Medical Society, which is a private, nonprofit corporation.

The present rated bed capacity is 202, including 37 bassinets, with the possibility of expansion to 300 beds, as one wing of the building is being utilized as a nurses' home at present.

The hospital is general in nature. It began in 1856 as the Cleveland Homeopathic Hospital in the downtown area. It remained in the downtown section until 1924, when it moved to temporary quarters on the east side until its new plant could be erected. The new building was completed and occupied in August, 1935.

Of particular interest are the arrangements of the patients' floors. Every floor is identical in plan, being divided into units of two rooms with a utility room between. All rooms are used for either one or two patients, thus affording the comforts and conveniences of semiprivate rooms, and at the same time enabling the same efficient operation that obtains in larger wards.

Mount Sinai Hospital: Mount Sinai of Cleveland is at 1800 East 105th Street opposite Wade Park. It is a general hospital of 225 beds and 45 bassinets, established in its present location in 1916. It is a modern, completely equipped institution, which enjoys an excellent reputation among the hospitals of the community. It operates a large out-patient department, the clinics of which are held in the mornings. While it is known as the Jewish institution of the community, its work is nonsectarian and the institution attracts a large following of patients from other religious faiths.

Polyclinic Hospital: Located at 6606 Carnegie Avenue, this is a nonprofit organization owned and operated exclusively by physicians. It is a general hospital with a total bed capacity of 105, including 15 bassinets. It is situated on one of the main traffic thoroughfares of the city in the center of a small manufacturing district and is thus called upon to render service to many traffic and industrial accident cases.

Serves Steel Mills District

St. Alexis Hospital: This hospital, located at 5163 Broadway Avenue on the southeast side of Cleveland, was established in 1884. It is a Catholic institution operated under the auspices of the Poor Sisters of Saint Francis Seraph. In 1925 a 100-bed wing known as the Leonarda Memorial was erected, bringing the total bed capacity up to 220.

St. Alexis is a general hospital, the majority of the patients treated being surgical cases. The hospital conducts an out-patient service. It is located in a populous industrial area in a steel mill and manufacturing district.

St. Ann's Hospital: St. Ann's Maternity Hospital, a Catholic institution, operated under the auspices of the Sisters of Charity of St. Augus-

Cleveland Clinic Hospital has as one of its special features a metabolic department, with a metabolic dining room for both in-patients and out-patients.

tine, is located at 3409 Woodland Avenue. It has a bed capacity of 59 with 59 bassinets and was established in 1873 as a maternity and infant home. Its original purpose was to care for unmarried mothers. Eventually the demand of private patients and their physicians for the safeguards which only a properly equipped hospital can provide for obstetric care opened the hospital to the married mother.

There is operated in conjunction with the maternity service St. Ann's Infant Home, in which efforts are made to bring into the lives of the children as many as possible of those experiences that are a part of the child life in a normal home.

The institution has during the sixty-three years of its work been a haven of refuge to thousands of unfortunates, and occupies a position of real importance in the community.

Has Large X-Ray Department

St. John's Hospital: St. John's of Cleveland, located at 7911 Detroit Avenue, is a Catholic institution, conducted by the Sisters of Charity of St. Augustine. It was opened in June, 1916, and has a bed capacity at present of 211. The obstetric division, remodeled within the past year, accommodates 28 patients and 32 infants. The institution is a general hospital serving a large area on the west side of the city.

In February, 1935, the x-ray department of this institution was enlarged to include two therapy units consisting of one 200,000 kv. and one 400,000 kv. constant potential supervoltage apparatus.

St. Luke's Hospital: St. Luke's Hospital Association of Cleveland, of the Methodist Episcopal

St. Luke's, its present plant completed in 1927, receives many accident cases, particularly traffic injuries.

University Hospitals is a corporation operating a group of important teaching hospitals; among them are the Babies and Childrens, Lakeside, Maternity and Rainbow Hospitals.

Church, occupies a modern and up-to-date building, which was opened in December, 1927. It is located at 11311 Shaker Boulevard on a tract of sixteen and one-half acres. The hospital has a total bed capacity of 500, with 337 beds for patients and 55 bassinets. A portion of one of the buildings is at present used for a nurses' home.

The work of the institution is that of a general hospital. It conducts an out-patient department and receives many accident victims from nearby residential suburbs and from traffic accidents occurring on the numerous highways leading into the city from the south and east.

Sunny Acres Sanatorium: The Cleveland tuberculosis sanatorium is located in Warrensville, about fifteen miles from the downtown area. Its elevation is the highest in Cuyahoga County, being more than 600 feet above the level of Lake Erie, particularly advantageous for the care of the tuberculous. The adjacent city farm consists of about 2,000 acres, all owned and operated by the city of Cleveland. Admissions are restricted to those patients who have a favorable prognosis. At present the bed capacity is 431, of which 108 are for children.

Under the auspices of the institution there are operated two out-patient clinics, one for pneumothorax cases, at 2500 East 35th Street, and a 48-bed hospital for ambulant cases at 3735 Cedar Avenue.

There are nine buildings on the sanatorium grounds, the oldest of which was first occupied in 1913, and the most recent, a 100-bed wing, in 1931.

University Hospitals: The board of the University Hospitals of Cleveland is an operating corporation responsible for operating Babies and Children's Hospital, Lakeside Hospital, including Leonard C. Hanna House for Private Patients, Maternity Hospital and Rainbow Hospital. It was organized in 1925. Its purpose is to provide a single centralized functionally controlled plan of management of the various member institutions under an

agreement whereby the board of trustees of each affiliating corporation has control of its own funds and property but turns all of its facilities over to the University Hospitals for operation.

The institution is affiliated with Western Reserve University, providing clinical and teaching facilities for students in the school of medicine, the school of nursing, the school of applied social sciences and the school of pharmacy. In addition, the hospital under its own auspices conducts a school for dietitians accredited by the graduate school of the university and also a school for graduate nurse anesthetists.

It has a total bed capacity of 819 beds and 115 bassinets. In the Lakeside building there are 81 beds for private patients and 227 teaching beds. In Hanna House there are 85 additional private beds for adult medical and surgical cases.

In Maternity Hospital, where the obstetric and gynecologic services are conducted, there are available 75 beds for private obstetric patients, and 51 beds for the staff and teaching service in obstetrics. One floor completely isolated from obstetric activities provides 18 beds for private gynecologic cases and 16 staff beds for teaching purposes. The teaching service in obstetrics conducts a large out-patient service, with six prenatal clinics located throughout the city. The majority of the clinic patients are delivered in the home under the professional supervision of the obstetric staff.

The Babies and Childrens Hospital unit provides 27 beds for private cases on pediatrics or children's surgery, 12 children's surgical teaching beds and 100 pediatric teaching beds. Rainbow Hospital for Crippled and Convalescent Children, located in South Euclid, has 66 beds for surgical and orthopedic cases and 34 for pediatric patients. The University Hospitals conduct a large out-patient service, facilities for which are located in the Lakeside building.

Near Western Reserve Campus

The oldest of the present group of buildings was opened in December, 1925. The present Rainbow building was first occupied in 1928, and the Lakeside and Hanna House buildings were opened in 1931. All units of the University Hospitals except Rainbow Hospital are located adjacent to the campus of Western Reserve University, just south of Euclid Avenue at Adelbert Road.

The institution provides community service both to private and indigent patients and teaching facilities for the various departments of the University which are affiliated.

Windsor Hospital: Windsor Hospital is operated by a private corporation for the purpose of treating nervous and mental disorders. Emphasis is placed on hydrotherapeutic treatment of patients. The hospital was the first private sanitarium in the vicinity of Cleveland to furnish occupational therapy to its patients. The institution has for many years been located at 4415 Chester Avenue.

In 1927 a branch of the hospital was established in Chagrin Falls, twenty miles southeast of Cleveland. Present plans call for a discontinuance of the Chester Avenue unit, with all of the activities to be transferred to Chagrin Falls. The present capacity is 110 beds.

Woman's Hospital: The Woman's Hospital of Cleveland is an outgrowth of the Women's and Children's Free Medical and Surgical Dispensary founded in 1878 by a small group of homeopathic women physicians. After thirty-five years of this service a general hospital for the care of men, women and children, which would give women physicians equal opportunity with men for hospital training and service, was established. The present bed capacity is 110 with 17 bassinets. Both the active and courtesy staff are composed of men and women physicians, as is the board of trustees. The institution is located at 1946 East 101st Street.

Exposition Is Added Attraction

The Great Lakes Exposition will be in progress during the hospital meetings. The exposition is being held on the lake front grounds immediately north of the public auditorium where the A. H. A. meetings are to be held. Its purpose is to commemorate the centennial of the incorporation of Cleveland as a city and to emphasize the industries for which the Great Lakes area of the United States is particularly well known. The exposition has attracted much favorable comment because of the many educational exhibits being shown.

Cleveland and its visitors this summer have been fortunate in that it has been possible for the Cleveland Museum of Art, located in Wade Park, north of Euclid Avenue at University Circle, to assemble an exhibit of paintings for the duration of the exposition, some of which have never been shown publicly before. The collection has attracted widespread and favorable comment from art critics.

Other points of interest include the metropolitan park system, Severance Hall — the home of the Cleveland symphony orchestra — the Terminal Tower, from one of the upper floors of which may be secured a bird's-eye view of the city from all directions, outstanding residential areas, and the municipal air port, one of the busiest in the world.

Graduate Work for Graduate Nurses

By MARION J. FABER
Cook County School of Nursing, Chicago

The further education of graduate nurses is still in a plastic stage due to the many deficiencies of nursing school education. One requirement it must fulfill is to fill in the gaps left by the inadequacies of the system

FOR the present graduate nurse education will have to be sufficiently varied in type to compensate for the inadequacies existing in the undergraduate nurse's education. As standards in the education of the undergraduate nurse rise and become more uniform through the evolution of a sounder basic curriculum for all undergraduate schools of nursing, the character of graduate nurse education will also become more uniform and will reach a higher level.

The need for graduate study is clearly indicated through the studies of the Committee on the Grading of Nursing Schools which show that there are too many poorly trained nurses and too few well trained nurses.

Courses of graduate study specifically remedy this in that such courses do not increase the total number of nurses in the profession or the present unemployment. The result of graduate study in most cases is that a nurse is better qualified to obtain either a higher salaried position or one in a field of nursing where more and better nursing care is required for patients.

Choose the Right School

A graduate nurse seeking to supplement inadequacies in her nursing education should be sure that the nursing school and hospital she selects have facilities that will actually add to her professional knowledge and skill. She should ally herself with a school of nursing which has sound standards; one in which she will not be exploited and where the safety of patients will not be jeopardized by inadequate care; one in which her education and experience will be definitely augmented.

In the final report of the Committee on the Grading of Nursing Schools, "Nursing Schools Today and Tomorrow," the conditions for a good nursing school are set down as follows:

1. The hospital in which the nurse is to practice must be approved by the American Medical Association, the American College of Surgeons and the state board of nurse examiners.

2. The nursing school must have a training school committee to protect its interests.

3. There should be a well prepared group of administrators, instructors, supervisors and head nurses.

4. The health of all nurses should be safeguarded and a reasonable number of days of illness cared for.

5. The minimum ratio of hours of classroom work (theory) to hours of practice on the wards should be one to seven. (In most schools today it approximates one to nine).

Any graduate nurse seeking a school of nursing in which she may increase her knowledge and experience should assure herself that the school has an adequate library where she may reenforce her practice in the field which she elects for graduate study.

There should be an adequate amount of clinical experience with a well organized and well planned program of theory and correlated practice. There should be a ratio of not less than one graduate to six students so that each patient will have at least three hours of bedside nursing per day. Any hospital school of nursing which offers graduate nursing courses should not be entirely dependent for the care of patients on either the graduate or undergraduate students. The paid graduate staff should be large enough to stabilize the nursing care of patients, so that the experience and education of graduate and undergraduate nurse students will not have to be subordinated to the needs of patients.

There are five groups of graduate nurses for whom graduate study on different levels would be advantageous. They are: (1) the graduate

nurse wnose nursing school does not require four years of high school at the time she graduates; (2) the graduate of the smaller hospital in which clinical experience is inadequate; (3) the graduate staff nurse who wishes to advance herself professionally; (4) the graduate student who wishes clinical specialization; (5) the graduate student who wishes to prepare herself for ward administration, teaching or hospital administration.

The need for supplementary education for the first group, those who have not completed high school, will gradually eliminate itself since the standards in all good nursing schools today require four years of high school for entrance. At the present time, however, there is still a group of women who are giving faithful service to the profession but are not high school graduates. These should be helped to complete their high school course so that they may have adequate security for the future. An editorial in the October, 1932, issue of the *American Journal of Nursing* states that every nurse should have at least a high school education for in no other way can she be relieved of a feeling of inferiority. Today she will not be accepted in any good nursing school for further graduate study until she completes her high school work. No nursing department should accept her for staff duty on any other basis if the standards of the profession are to be raised. She will also find herself unable to qualify for civil service without her high school credits.

Carrying on High School Work

It has been found possible in some nursing departments to allow these graduates to continue their high school work while on the job, reducing the graduate staff salary to correspond to their reduced hours of work. Such nurses do not have the full rank or privileges of the regular staff nurse during this time but they can be given more responsibility and more actual nursing duties than an attendant. As soon as they complete their high school course, they should be eligible for regular staff duty or for further graduate study if their previous record of work warrants eligibility.

The second group may be divided into two subgroups: the graduate of the smaller hospital, where clinical experience is inadequate for well-rounded nurse education, and the graduate of such special hospitals as tuberculosis, children's, contagious or mental which necessarily give a one-sided training course because of emphasis upon one phase of disease only. The length of the course planned for either of these two subgroups will depend entirely on the amount of deficiency in the various services of their undergraduate nursing courses. Each graduate should have a special program planned to meet her individual deficiencies. This requires careful study and expert knowledge on the part of an administrator of considerable experience in nursing education. Graduate students in such courses (which are basic) should be given the same course content as undergraduate students, but the department head should have separate conferences with them and if possible they should be taught in classes where there are no undergraduate students.

The hospital departments considered as essential and basic by the grading committee for practice in undergraduate nursing as set forth in "Nursing Schools Today and Tomorrow," are medical, surgical, maternity, pediatrics, tuberculosis, mental, communicable, out-patient and home.

No School With Less Than 50 Beds

No hospital should maintain a school of nursing if it has less than fifty beds, and no school of nursing should attempt to train students unless adequate affiliation in deficient basic services is provided. In addition, there should be in each department of the hospital a variety of typical diseases that will give the student sufficient experience to meet the conditions most likely to occur in any community. Special hospitals are particularly lacking in the variety of clinical material necessary to meet the conditions in any typical community. The training must be strengthened either by adequate affiliation or graduate study of the above type.

The need for supplementary courses for the group will eliminate itself because of the growing realization of state boards that more adequate undergraduate affiliation for schools with limited clinical facilities for teaching is a necessity, and because of the growing tendency of schools with limited clinical teaching facilities to substitute graduate nurse service for student service, thus eliminating schools of nursing which have in the past graduated inadequately prepared nurses.

The third group for whom graduate study is a stepping stone to professional advancement is the staff duty nurse. This nurse has already proved her worth in that one capacity and wishes to improve her status. Shall we allow her to take any of the courses which we offer the nurse who has come for graduate study? Will this not tend to discourage graduate study? May we not look to professional education other than nursing to answer this question? Any individual employed by an organization may take courses of study, provided such courses of study do not interfere with his work. A staff nurse should always be employed with the understanding that she is to be

placed where the nursing needs are greatest, that she is employed so that a program of theory and practice can be planned for undergraduate and graduate students and be carried through without depriving patients of necessary nursing care.

On this condition only may a staff nurse register for further study. If her hours of work are subject to frequent change (and they must often be changed to fit the needs of the department) she and not the undergraduate or graduate student must relinquish her right to study. However, a staff duty nurse can often be placed on a service which is of little or no educational value to the student nurse. If three staff nurses, all interested in a program of study, were placed on such a service or ward, one each for days, afternoons and nights for a period of three or four months or even longer, an effective program of study might be planned over a considerable period of time.

Many Types of Courses Needed

None of these above groups represents the real issues in graduate nurse courses since the need for such courses is likely to be of longer or shorter duration in accordance with the time required to raise educational standards to a uniform and adequate level. Graduate nurse courses of the future are likely to evolve into several distinct types, of which at least one will be a course planned for clinical specialization and another, a course planned for administration and teaching. These include the fourth and fifth groups of graduate nurses for whom graduate study is planned.

For the group which wishes clinical specialization there should be definite prerequisites of a high order and specific objectives.

A nurse who registers for a clinical specialty should come from the upper third of her high school class. The administration of standardized tests given each group of applicants helps to determine the levels of intelligence, some of the aptitudes and something concerning the emotional stability of the applicant. In addition to having a good mental capacity, adequate aptitudes and at least average emotional stability, the nurse registering for such a course should have sound general and professional education and experience in her undergraduate nursing course.

The clinical course, according to the statement of one of our leading nurse educators, should be on a senior college level, and should therefore earn credit toward a bachelor's degree. She cites the specialties most in demand as pediatric nursing, psychiatric nursing, communicable disease nursing and surgical nursing. Experienced nurse educators admit that as yet there is no "pattern" for such courses but there should be time for observation, clinics, case studies, special projects, and close contact with patients.

The fifth and last group who wish to study for head nurse work, administration or teaching, should have had excellent basic preparation in their undergraduate nursing course and should have shown promise of developing into skilled teachers, supervisors and administrators.

As a specific nursing prerequisite, either the course in the clinical specialty in the same field of nursing in which the graduate nurse wishes to teach or become an executive, or evidence of successful experience and adequate training in this field or related fields should be required. As a background such courses as psychology, sociology, economics or methods of teaching should be required.

Administrative courses should be planned in definite sequence with correlating levels of progressive practice work. Few graduate nurse courses fulfill this requirement at the present time.

There are two courses of graduate nurse study which will need careful planning and further development in the years to come: (1) the course in a clinical specialty planned for the well prepared graduate, and (2) the courses in teaching and administration planned for the graduate nurse who has satisfied the requirements prerequisite for advanced study.

What the exact content and sequence of such courses is to be, or what correlating practice may be planned, is still somewhat a matter of experiment requiring considerable time and study.

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Self-Insurance for Saving

Someone once said that it is easier to make money by saving than by earning and this is actually true in hospital work. With this statement in mind, we made a study of the costs of compensation insurance and found that about 60 per cent of the cost of our coverage was for medical and hospital expenses. We also found that numerous commercial and manufacturing firms assumed their own risk in such cases and became self-insurers. On July 1, 1935, this hospital decided to cancel its policy with a commercial company and become self-insured. For six months following this date approximately $700 in premiums were saved and the total cost to the institution for the same period was $40. In assuming the risk as mentioned above it is wise to set up a reserve each month to take care of unexpected accidents. In addition, an institutional safety program must be promulgated and enforced.

Someone Has Asked—

Whose Responsibility Are Adequate Case Records?

The responsibility for adequate case records falls on the superintendent, for inadequate case records are a reflection upon any well governed institution.

All new patient admissions should be posted on respective divisions by the supervisor. They then become the direct responsibility of the intern who is on this division. These postings are checked daily by the residents. It is their duty to see that the records are completed within the required time. This, of course, applies to such parts as are made by the hospital staff.

A record committee should be composed of members of the staff to whom all incomplete records may be referred by the record librarian. This committee should meet regularly and refer back to staff members incomplete charts for the required additions. Chronic offenders should be referred to the superintendent who in turn may notify the offender that unless his records are completed by a specified time privileges of the hospital will be withdrawn. In this connection it is a distinct advantage to read the names of chronic offenders in a general staff meeting.

The matter of policing records is, and probably always will be, a problem to hospital superintendents and one on which too much stress cannot be put. Experience has proved that this is an invaluable service rendered to both staff and patients.—GEORGE D. SHEATS.

How Can Hospitals Keep in Touch With Family Doctors?

Community physicians complain that when they send patients to a hospital ward they are not always kept informed of the developments in their cases. Even when operation or death occurs they do not always have knowledge of these important events. Such a complaint is wholly justifiable. Furthermore, the admission of a patient to a ward of the hospital sometimes means that the family doctor not only temporarily loses control of his patient but also that the patient is likely not to be referred back to him when discharged. This is unjust.

There are certain simple and inexpensive practices which have as their aim the better cooperation of the hospital with the referring physician. The notification of a community physician that a member of his clientele has been admitted to the institution's accident ward is but a reasonable act. The communication with the family doctor when his ward patient becomes critically ill or dies should never be neglected. When the patient is about to be discharged from the hospital the referring physician should be notified. No ward patient should come to operation without the family physician knowing a day in advance that this is to occur.

The scientific departments of the hospital are splendid media of contact with community physicians. Every encouragement should be given local nonstaff physicians to use the x-ray, laboratory and physiotherapy service of the institution in the treatment of his patient. Hospital publications and bulletins should be sent to a mailing list which contains the names of all doctors within a reasonable radius of the hospital. The institution which forgets that the confidence and respect of the general practitioner are highly important factors in its success is likely to experience a dwindling patronage and a declining prestige in its community.

Of What Does Staff Loyalty to a Training School Consist?

From time to time one suspects that all is not well between the members of the hospital staff and the graduates and officers of the institutional training school for nurses. The visiting physician who is inclined to criticize loudly entertains his colleagues in the staff room with tales of nursing inadequacies. He does not believe that psychology should be taught to nurses and moans long and loudly for the return of the old-time nurse.

The nursing school alumnus is inclined to object when she sees graduates of other schools nursing patients in her own hospital. Some staff members, understanding the aims of the school for nursing and believing in the fair dealing of its officers gladly give their time as lecturers.

It is not always the doctor's fault when he secures the services of a nurse not trained at his hospital. The nurse who will not accept night cases, who spurns twenty-four-hour service, who refuses to respond because she has theater tickets for the evening does not hold the confidence of the doctor and he is therefore not inclined to call for her help.

Staff loyalty to a training school means that only constructive criticism will be offered. It implies an absence of public harangue in regard to nursing defects and the engaging of its graduates when the interests of the patient are thus best served. Loyalty to the staff on the part of the nurse should dictate a willingness to accept the undesirable along with the desirable patient, the difficult with the easy, night service as well as day service. The training school is an important part of the hospital organization and its pupils and graduates should not be humiliated by having inflicted on them caustic criticisms.

Is Cost of Administering Endowment Funds an Operating Expense?

Strictly speaking, the costs of administering an endowment fund are not part of the costs of administering a hospital. An endowment fund is one thing, a hospital another. The net earnings of an endowment fund are hospital income, after subtracting the costs of administering the fund.

In some instances the costs of administering an endowment fund are so insignificant in amount, and so closely tied up with the general administration of the hospital office, that a segregation of expenses could not be easily achieved. The separation of the costs of administering the endowment fund may involve an expenditure for bookkeeping which is greater than the value of the information obtained. In such a case it is sufficient for the administrator to point out in his report that his statement of hospital operating expenses includes a small allowance for administering the endowment fund.—C. RUFUS ROREM.

If you have any questions to ask, the Editors will be glad to discuss them in a forthcoming issue

What Causes Hospital Fires?

By V. L. DOUTHIT
Fire Protection Engineer, Chicago

This article concludes a series of six devoted to the elimination or reduction of fire hazards. Free inspection service is still available. Fire protection engineers will gladly survey, without obligation, hospital property to suggest methods of eliminating hazards and safeguarding lives, or will provide information on insurance. Write The Modern Hospital

DID you perchance read that excellent article "Hot Magic" by Paul W. Kearney that appeared in the December, 1935, issue of the *Reader's Digest* (condensed from the *Family Circle*)? If you did read it, you may have felt that the author overemphasized two relatively infrequent causes of fire, but records show that approximately one-fourth of hospital fires are caused either by electricity or spontaneous ignition. Do not accept the fallacious belief that the common causes of fires in general are not applicable to hospitals, for fire loss statistics show that the causes of hospital fires are not particularly different from those of other occupancies.

Several records of the causes of fire in hospitals have been maintained, some on the basis of the number of fires and others on the basis of the amount of loss. They cover varying reaches of territory for different periods of time.

The following table, prepared from records of the National Fire Protection Association, an international clearing house for authoritative information on fire protection and prevention, is typical of such studies and discloses the causes of a group of 104 hospital fires over a wide area:

Electrical causes	23
Sparks on roofs	12
Ignition of grease or flammable liquid on stove	6
Careless smoking	5
Miscellaneous known causes	5
Stoves, furnaces, boilers and their pipes	4
Incendiarism	4
Spontaneous ignition	4
Defective chimneys and flues	3
Lightning	3
Defective oil burner	2
Steam pipes	2
Careless use of matches	1
Escaping gas	1
Upset lamp or stove	1
Careless fumigation	1
Gas jet igniting curtain	1
Gasoline	1
Unknown	25
Total fires	104

Let us analyze these figures to see if we cannot unearth some examples of gross carelessness.

First on the list are electrical causes, accounting for 23 out of 104 fires. Of the 23 fires caused by electricity, considerably more than one-half were from defective wiring. Other forms of electrical causes were: electric iron left on, short circuit in x-ray machine, short circuit on Christmas tree lights, short circuit igniting gas in elevator well, short circuit in lighting fixtures, electric light bulb igniting holiday decorations, defective elevator motor, electric light bulb igniting ray film, radio charger left on, arc resulting from fuse plugged with pennies.

These, then, are some of the electrical causes of hospital fires. Do we need any more persuasive argument of the need to curb the activity of the hospital handy man, the jack-of-all-trades and master of none? It behooves us to curb him before he annihilates us. Electricity, although a faithful and powerful servant when guided by knowing hands, is a brute "gone hog-wild" under the guidance of the ignorant. We can do much to reduce this major cause of fire if we insist on first-class electrical installations and repairs by qualified engineers, and electrical products that bear the stamp of approval of Underwriters' Laboratories.

Next in predominance is the number of fires originating from sparks on roofs, 12 of the 104 fires being so caused. Wooden roofs are becoming less and less common in new hospital construc-

tion, but many hospitals are still so covered, and the number of fires originating there is evidence of the potential hazard existing in that form of roof construction. Sparks attack not only roofs surfaced with wood shingles, which are notorious for the speed with which they ignite, but also the wood sheathing and wood supports under approved composition surfacing, the wood cornices and other combustible roof structures.

Substantial fireproof construction — concrete, reenforced concrete or tile — is the sure means of eliminating this hazard and of reducing the number of roof fires.

The number of fires caused by the ignition of grease or flammable liquids on stoves — 6 out of 104 — reflects poor housekeeping and general carelessness. Grease on stoves, syrups and floor wax boiling over, rubbing alcohol and medicinal oil igniting while being heated contribute to this cause of fire. Employees need to be cautioned about such simple things as keeping the stove clean, keeping highly flammable and volatile substances away from hot stoves, and properly attending those articles that may be safely heated on ordinary stoves.

Smoking Room May Be Money Saver

Careless smoking and careless use of matches caused 5 of the 104 hospital fires. Most of these fires were caused by cigarettes dropped into a film drawer, into piles of oily rags, behind a radiator or on a curtain. One was caused by a lighted match tossed unceremoniously into a clothes chute. That these fires were preventable is readily apparent.

In many hospitals smoking by the personnel when on duty is strictly prohibited, but our investigations disclose that employees do occasionally, if not frequently, smoke while on duty. The consensus of fire prevention engineers is that it would be far safer from a fire prevention point of view to provide a smoking room for the use of the staff and to permit occasional smoking there rather than to run the risk of the demolition of the hospital and the accompanying loss of life as the result of a cigarette hastily and carelessly tossed aside in an effort to avoid detection.

Of that group titled miscellaneous known causes, which was responsible for five of the fires, these were the elements: rubbish near a heater, explosion of disinfecting fluid, film igniting in motion picture machine booth, boiler support giving way and breaking oil pipes, and films in storage igniting. To these may be added several of the less prominent causes of the original list: careless use of matches, escaping gas, upset lamp or stove, careless fumigation, gas jet igniting curtain, and gasoline igniting, all obvious acts of carelessness or poor housekeeping. But in this group of 104 fires no less than 22, almost a quarter of them, were caused by just such simple indiscretions.

Our classification of causes of 104 hospital fires indicates that 4 were caused by stoves, furnaces, boilers and their pipes, 4 by defective chimneys and flues, 2 by defective oil burners and 2 by steam pipes. Since these are all rather closely associated, let us consider them together as heating and power causes. This group caused 11 of our 104 fires, or a little more than one-tenth of the total.

Other studies place this cause even higher in importance; some indicating that it is a cause of as many as 21 per cent of all institutional fires. Whether heating is a cause of 10 per cent or 21 per cent of all hospital fires, or some percentage in between, it is an important consideration. All heating furnaces and boilers should be situated in separate fireproof buildings entirely away from the hospital. If they must be located in the basement of the hospital, they should be in separate fireproof sections, cut off from the remainder of the building by masonry walls and ceiling and with openings, if openings into the main building are necessary, protected by approved, automatically operating fire doors.

A few years ago an improperly installed oil-fired boiler in a three-story stone, wood-joisted institution fell, breaking the fuel oil pipe and setting fire to the building, causing the loss of five lives. The provision of an isolated boiler house in this instance would have avoided that loss of life and property.

All chimneys should be of brick laid flat from the ground or ledged solidly into masonry walls. Chimney walls should be at least eight inches thick and have tile flue lining. Stovepipes or boiler breeching should never pass through or near combustible walls, partitions or floors. Chimneys and pipes should be thoroughly cleaned at least once each year to prevent large soot accumulations; these become ignited and spread to roofs of buildings.

Guards for Steam Pipes

Steam pipes, although comparatively frequent causes of fire, are not generally recognized as such. Guards for steam pipes should be of metal, and pipes should in all cases have adequate clearance from combustible material.

Of the four hospital fires listed in our classification as having been caused by incendiarism, all were started by mental patients or by pyromaniacs not inmates of the hospitals involved in the fires.

Spontaneous ignition, a cause of 4 of the 104 fires, is another preventable cause. Oil mops and oily rags should not be kept exposed in closets. Such mops should be stored in tight metal containers, and accumulations of oily rags, rubbish, papers and the like should not be permitted.

Lightning rod equipment is now tested and approved by Underwriters' Laboratories, and all hospital buildings situated on high or otherwise exposed points should have that protection.

Other causes of hospital fires not specifically brought out in this study are the use of high volatiles, dangerous chemicals, x-ray films or other films not of the "safety" or slow-burning type. It goes without saying that with the exception of a limited quantity of anesthetic gases and chemicals kept in incombustible rooms and containers, these articles and commodities have no place in the modern hospital.

The 104 hospital fires studied were fairly well distributed throughout the day and night, the number occurring between 6 a.m. and 6 p.m. just about equaling those occurring from 6 p.m. to 6 a.m. Sixty-two per cent of the fires occurred during the winter months in the period from November 1 to May 1.

Half of the hospitals involved had brick walls with wood interiors, 47 per cent were of frame construction, and only 3 per cent were of fire-resistive construction.

The following table indicates the large portion of these hospital fires that resulted in severe losses: slight loss, 19; loss under $1,000, 10; $1,000 to $10,000, 17; $10,000 to $50,000, 29; $50,000 to $100,000, 10; more than $100,000, 4; not stated, 11. Of these 104 hospital fires 24 resulted in total losses.

Five Points to Remember

Summing up the six articles of this series, the following main points have been made:

1. The importance of erecting hospital buildings of the sturdiest fireproof construction, and the necessity for eliminating fire hazards in hospitals of the nonfireproof type.

2. The need for adequate first-aid fire fighting equipment for hospitals, designed for use by the hospital personnel to halt fire before the arrival of the fire department. In the second article the kinds of equipment best suited for hospital use were suggested, together with instructions for the care, maintenance and use of such equipment.

3. The adequate training of hospital personnel to prevent and combat fire. Suggestions were made in the third article for the establishing of a hospital fire corps with a fire marshal to direct the work, and monitors and guards to carry it out. A type of fire drill suitable for hospitals and a plan of procedure to follow in the event of fire was another feature of this topic.

4. The desirability of transferring the fire risk from hospitals to insuring companies established for that purpose. The fourth article suggested a number of points to watch in the purchase and writing of hospital insurance policies.

5. The desirability of insurance against other types of risks, the general purpose of such insurance and the reasons for providing it were covered in the August issue.

Repeatedly during these articles it has been suggested that, in providing improvements either in your property or in your insurance, you should consult the rating or underwriting organization in whose jurisdiction your hospital lies, or the engineering department of your insurance company. From them much assistance can be secured without cost, the benefits of which may be in the form of a saving in insurance premium or in the more important form of providing a safer shelter for patients.

Our Friend the Funeral Director

"How can we win over the funeral director?" "If only the funeral director would not interfere." These are comments often heard from staffs after an unsuccessful attempt has been made to secure consent for a postmortem examination.

The funeral director does not have to be "won over." He makes his living out of undertaking and is usually cooperative and helpful, if given half a chance. He is the staff's "best bet" if his rights are respected and the autopsy does not prevent him from turning out a "good job." Only too frequently he is delayed for trivial reasons and with disregard for his time. The pathologist must go to lunch or a clerk must keep him waiting needlessly. Nothing will do more to antagonize him than to neglect to prepare the body properly for embalming. The funeral director who, when treated fairly, still maintains an antagonistic attitude can be made to see the folly of his ways by a tactful administrator.—*Jacob Goodfriend, Assistant Administrator, Montefiore Hospital, New York City.*

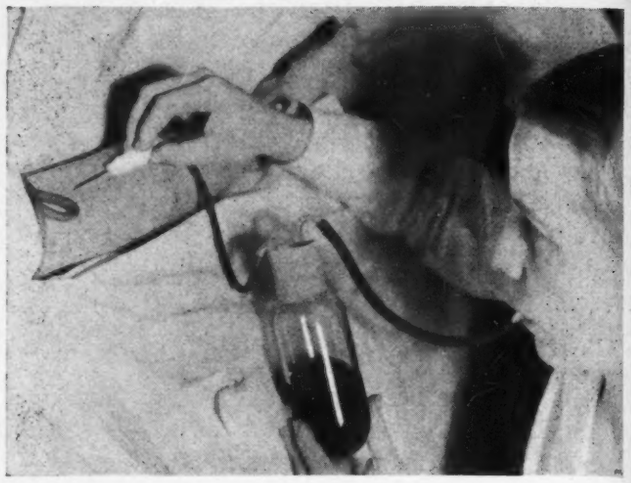
A Polished Floor Proves Costly

The London correspondent of the *Journal of the American Medical Association* reports the case of a widow who when visiting her son, a pay patient in the Westminster Hospital, put her foot on a mat which slipped on a polished floor. She fell on her side and as a result of the injury she received, her left leg became an inch shorter than her right.

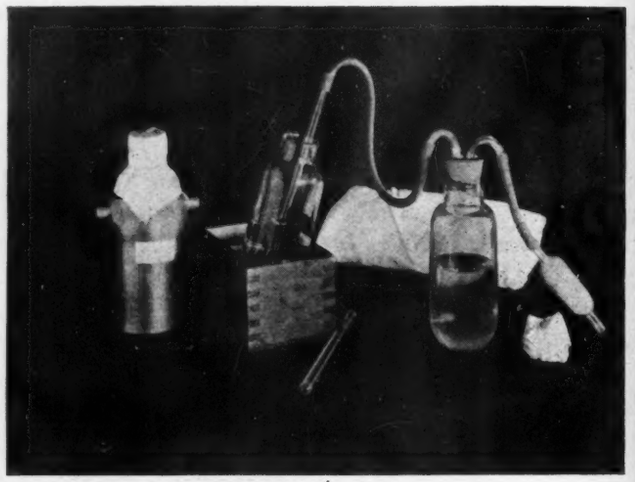
She brought an action against the hospital. The judge said that the hospital authorities ought to have known that it is dangerous to place a mat on a highly polished floor and that it might slip. They ought, he said, to have secured the mat. He awarded damages of $14,000.

Health Out of Sickness

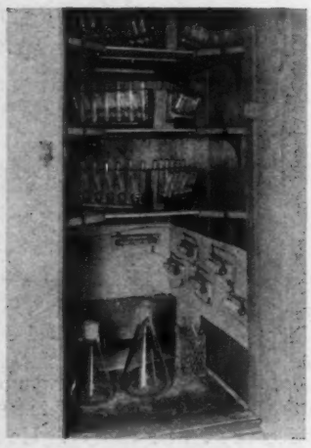
SCARLET FEVER, measles, mumps, chickenpox and poliomyelitis all carry less dread to Milwaukee residents now. A relatively new weapon in the physician's armamentarium aids in their control. From adults who are convalescing from the diseases, blood is collected which is made into convalescent serum. Various types of serum, if used early enough, will prevent the occurrence of the diseases or lessen their severity.



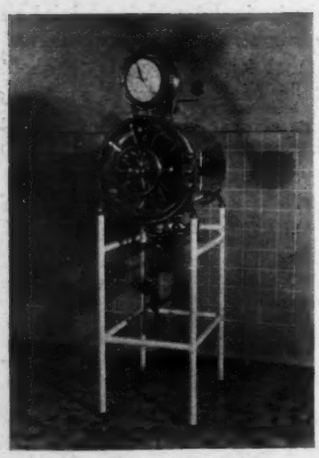
Bleeding.



Centrifuge and serum sets.



Incubator.

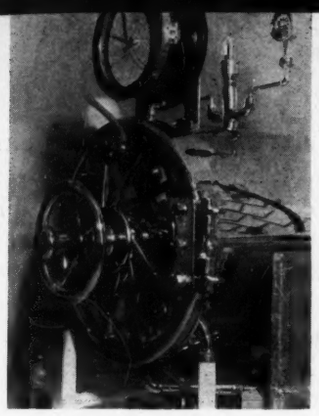


Autoclave.

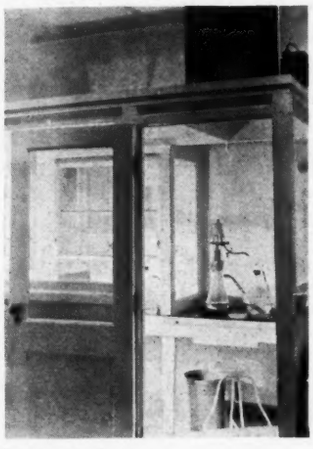
Centrifuge.

The Milwaukee Serum Center, some of the equipment for which is shown here, was established at Columbia Hospital in March, 1935. It is copied from the Samuel Deutsch Serum Center at Michael Reese Hospital, Chicago. The early organization was directed by Dr. William Thalhimer, the founder of the Chicago serum center and at present the head of a serum center in New York City.

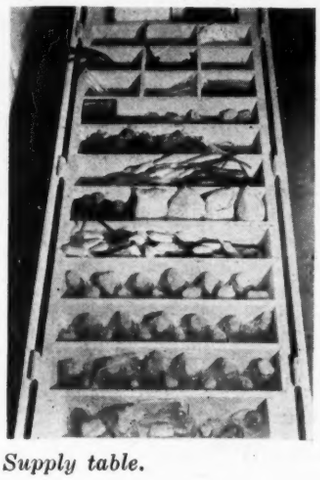
The money to establish and equip the center, approximately $10,000, was donated by a Milwaukee citizen who also guaranteed to meet the deficit for the first year. This deficit amounted to $2,813.88, not considering accounts due, $1,460, and serum on shelves, valued at $1,865. During nine months of the year 1935 the center had receipts from the sale of serum amounting to $3,685.44 and expenses of $6,499.32. Also there are accounts due of almost $1,500 and a stock of serum on hand valued at $1,865. Thus the center is already practically self-supporting.



Autoclave.



Dustproof room.

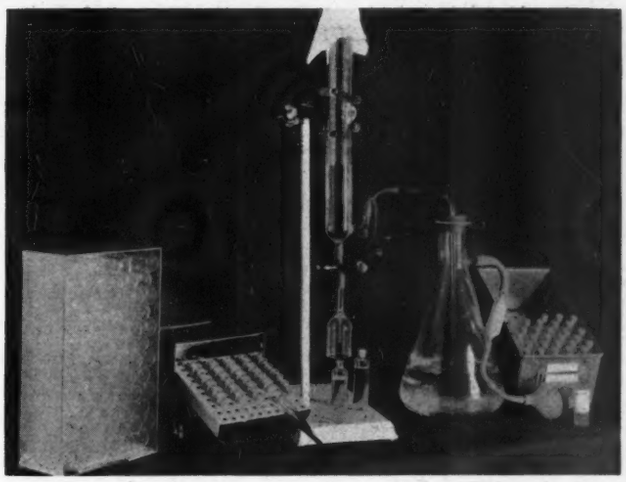


Supply table.

During the twelve months ending June 30, 1936, the center collected 134.5 liters of blood and distributed a total of 2,686 vials of serum. These vials are of various sizes, ranging from 5 to 20 cc. They have been of the following types: scarlet fever, 2,249 vials; measles, 308 vials; mumps, 54 vials; chickenpox, 2 vials, and poliomyelitis, 30 vials. This serum is sold to those able to buy it and distributed without charge to others as long as the supply lasts.

The serum center is on the ground floor of the new hospital building. The equipment includes a dustproof room, sterilizer, centrifuge, electric bake oven for dry sterilization, acidproof sink, water still, large electric refrigerator and a large incubator. Doctor Thalhimer acts as an advisory director and the personnel includes a part-time physician, Dr. Maurice Hardgrove, a technician, a secretary and a boy to clean glassware.

The blood is collected by needle puncture of an arm vein, after novocaine anesthetization of the overlying skin, into a 250 cc. heat resisting glass centrifuge bottle. After clotting and centrifuging, the serum is transferred by suction in a dustproof room into another heat resisting glass bottle, at which time samples are inoculated into fermentation tubes and another sample is taken for Wassermann and Kahn tests. Only those serums are used for which these tests are completely negative and the sterility tests are negative after at least seven days' incubation. Then the serums are pooled, filtered and bottled and samples again are cultured.



Vialing apparatus.

Storage icebox.

Calling Nurses' Aids to the Rescue

By GEORGE WALKER, M.D.
Baltimore

RECENT studies show that about 55 per cent of the work being done in hospitals by pupil nurses and by graduate nurses is really nonprofessional in character and could be performed by educated and intelligent but not technically trained persons.

It seems to be sound economy for hospitals to recognize this fact and to delegate these duties to a new classification of employees — nurses' aids. Such an occupation might be expected to appeal to intelligent young high school graduates — the same group from which pupil nurses are drawn. For these young women a career as nurses' aids would provide an immediate livelihood without the necessity of a long training period; for hospitals the plan would provide better service to patients, by relieving trained nurses of the burden of routine, nonprofessional duties, and would reduce operating costs.

In many cases the use of nurses' aids and graduate nurses would permit the abandonment of training schools with an actual saving in money and with improved service to the patients.

The requirements affecting the hospital are these:

A girl must not be less than eighteen years of age; she must be a high school graduate; she must be in sound physical health; she should receive a salary of from $20 to $30 a month with full maintenance and laundry; she should have a single room in the nurses' home; she should have her meals with the nurses in their dining room; she should be accorded the social privileges now enjoyed by pupil nurses; she should be subjected to the same discipline as pupil nurses; she should receive her uniforms free; she should receive free hospitalization when sick; the nurses' aids who prove themselves apt and who desire to become trained nurses should be recommended for admission to schools of nursing.

On the girl's side the following facts may be enumerated:

This vocation opens a new field for her; she will have full maintenance and money sufficient for ordinary expenses; she will have a comfortable single room; she will be provided with wholesome food; she will work eight hours a day; she will not have to do heavy work such as cleaning floors and windows or heavy scrubbing; she will be placed on the same social status as pupil nurses; the work will be interesting; the association with the nurses and with the medical staff of the hospital will be agreeable; the discipline and regular duties will be beneficial; her experience in coming in contact with the sick and dying, in emergency work in the out-patient department and in the procedures in the operating room and other sections of the hospital will show her the serious side of life and teach her invaluable lessons; finally, the work should be looked upon as a continuation of her education, a kind of postgraduate course.

The family would have the assurance that the hospitals would give to these young nurses' aids the protection that is now being given to pupil nurses.

In answer to criticisms as to the lowering of the standards of the nursing service, it may be said that under this plan graduate nurses would do all the strictly nursing service, whereas in hospitals that have training schools the nursing service is now done by pupil nurses. Since the nurses' aids come from the same group of girls as those now taking up training, the work would be done just as satisfactorily by them as by the pupil nurses.

With the proper proportion of graduate nurses and nurses' aids, the nursing service will be better and the cost lower than with the training school. Forty graduate nurses and forty nurses' aids should be sufficient to take the place of 100 pupil nurses.

Only a few hospitals offer positions such as are outlined in this study, but the scheme is so advantageous to both hospitals and young women that, in my opinion, it should be widely popularized.

Would nursing service perhaps be better and hospital costs lower if only graduate nurses did the professional nursing, and if nurses' aids were trained to carry the burden of routine and nonprofessional duties?

A Family Conclave

By JOSEPH C. DOANE, M.D.

In fancy let us sit in at a meeting of an administrator and his personnel, says the author, who regrets the infrequency of hospital staff conferences

THE time is nine-thirty on a Monday morning, the place the administrator's council table or the board room. It is hoped that the visitor will be agreeably surprised to observe that this conference does not consist of a prolonged soliloquy by the administrator. It is not a scolding session or a disciplinary meeting. The wise administrator acts as a dignified presiding officer, allowing his associates to consume much of the time in making their reports.

The first official act is the reading of the minutes of the last meeting by the administrative secretary. A few moments are spent in checking the accomplishments since the previous meeting and in receiving special reports. A study having been requested as to the number of free cases treated in the dispensary, the head of the social service department tersely furnishes this information. She also supplies interesting statistics on the amount of insulin issued per week and the amount paid for. The storekeeper gives a report on the relative cost of buying and making glucose solution.

While these matters of unfinished business are being discussed, the stenographer takes note that the following persons are present — the assistant superintendent, the chief resident physician, the chief nurse, the dietitian, the social worker, the chief engineer, the credit worker, the storekeeper, the occupational therapist, the chiefs of the clinical laboratory, x-ray and physical therapy departments, the housekeeper and the pharmacist. It is noted that each of these department heads, apparently appreciating the opportunity of meeting with the executive, has brought memoranda to serve as the basis of his or her report.

An air of informality is created by the seating arrangements, the assistant superintendent, the chief nurse and others taking places about the table which have no relationship to their supposed importance in the hospital organization. Moreover, reports are not requested in order of the importance or seniority of the department head and usually the order of calling for comments is varied from time to time.

At this meeting the chief resident physician is first called upon. Being Monday morning and the time for the weekly conference he is resplendent in his immaculate white uniform. He speaks of the medical happenings of the week. He narrates the circumstances of a broken needle in a patient's tissues, commenting on the grade of needles purchased and suggesting the possibility of their gauge being changed from twenty-four to twenty or even eighteen, thus increasing their strength. He suggests to the superintendent that the charge for the x-ray examination necessary for the discovery of the presence of the needle be canceled since the accident was not in any way the fault of the patient.

He asks what can be done in regard to limiting the number of chronic patients occupying acute ward beds. He compliments the intern staff upon averting a scarlet fever quarantine by the discovery in the accident ward of a patient suffering with this disease. He asks for a better and safer method of storing gas tanks, and refers the matter of thus averting the danger of an explosion to the superintendent, who in turn asks the chief engineer to note this fact.

He reports the need for a new oxygen machine because so many cases of pneumonia are being treated in the medical wards. He requests that a truck be built for the transportation of fracture equipment. Finally he reports the sickness of an intern which leaves the surgical service crippled by his absence.

The superintendent having noted these matters presented by the chief resident physician assigns each to the proper department head and asks for comment upon each item at the proper time.

The chief nurse is next recognized. She complains that physicians, both visiting and resident, are smoking in the ward dressing rooms. She reports the delay of an intern in reporting on the ward following a night call. She discusses her plans for covering vacation absences and states

the number of additional nurses she will require for this purpose. The superintendent here asks her to prepare a schedule and to bring it to his office for approval.

The chief nurse continues by requesting an improvement in the type of food served at the nurses' night supper. The dietitian is observed making a memorandum of this request. The need for renovation of ward utensils, such as bedpans, enamel urinals and pus basins is then stated. As spring is approaching, the chief nurse mentions the need for early placement of screens because of the presence of flies in wards and diet kitchens.

A broken toilet in the nurses' home which has been the subject of many requests is next described by the chief nurse, and she adds that of late the cleaning in the nurses' home has been improper and altogether too tardy. She reports a complaint made by a patient as to the occurrence of noise during the visiting hour.

The superintendent pauses for a moment here and discusses methods by which noise prevention can be worked out, requesting the chief nurse and the chief resident physician to make a further report on this matter at a later meeting. The chief engineer is requested to inspect the wheels of all movable equipment to learn whether the quiet of the hospital corridors will be favored by their repair or replacement. The persons affected by these comments by the superintendent make a mental or pencil note as to the part they are expected to play.

Dietitian Names Her Problems

The dietitian is next in order for report. She comments on the rising price of foods generally and makes some broad statements as to the methods which she has adopted leading to economy. The department heads understanding the problems of the dietitian, are asked to be more patient and less critical in discussing the character of meals until a changing season brings about a reduction in the prices.

The dietitian reports that ice boxes on the private floors contain too much unused liquid nourishment at the end of the day and the chief nurse is observed recording this fact. The loss of linen on private floors is also commented upon. She declares that she does not believe that the high calorie table being conducted in the nurses' dining room justifies its expense because so few nurses eat there.

The storekeeper is asked whether the quality of fish purchased is of high standard. The dietitian states that on a previous week the fish furnished was of inferior quality. The storekeeper is here permitted to comment upon the fact that his ice boxes are not cooling properly. The chief engineer sharpens his pencil.

The dietitian continues by remarking that she believes the gas stoves in the main kitchen are inefficient and should be overhauled or replaced. She asks for better facilities for storing her mops and comments on the slowness of the removal of garbage from her diet kitchen. She requests the speeding of a dish requisition for the private floor and the storekeeper informs her that these articles arrived that morning. She reports difficulty in preventing stealing from the kitchen, stating that she suspects that the chef is dishonest.

An Accounting Is Requested

The superintendent before passing on to the next member of the staff comments upon the amount of money spent for food in the past as compared with that of the present year and requests the dietitian to furnish him comparative data on a study showing the increase of expenditure in hospital foods as compared with the reported percentage rises of food in the wholesale market. This matter, the dietitian remarks, will be presented at the next meeting.

The social worker reports that she is having much difficulty in equaling past records insofar as collections in the dispensary are concerned; that few pay the twenty-five cents a visit and that many of those who are accustomed to pay a part of this sum are unable to make any contribution at all. The superintendent asks as to the collection methods she employs and, apparently satisfied, states that there has been a great change in the type of person using the dispensary during the past six months, those who are able to pay a clinic fee being accepted in doctors' offices apparently with a promise of paying a part or all of their bill later.

The social worker requests authority to furnish car fare for the transportation of her workers on hospital business. The superintendent asks for a study as to the relative cost of the purchase and the maintenance of an inexpensive car as compared with the amount spent in the transportation of workers, patients and others coming under the social service department.

The social worker regrets the lack of understanding and cooperation of visiting chiefs with her department. She speaks of the help which she has received from the head nurses for which she expresses thanks. A new typewriter is needed in the dispensary and the main social service office requires repainting. She concludes by stating that she feels that the medical aspect of her work is being more and more slighted and that messenger service, the securing of braces, clothes,

food and even postmortem permissions is consuming too much of the time of her staff.

The chief engineer, unusually spick and span with no evidence that on this morning he has spent any time in the boiler room, is next called upon. He reports that an automatic elevator is being misused by nurses, that doors are being left open and that the use of this equipment is being hampered by this carelessness. The superintendent refers this matter to the chief nurse. He announces that a new water heater is to be installed in the children's hospital and that on one or more evenings of the coming week the nurses must be without hot water for awhile.

The chief nurse here asks why the steam pipes in the nurses' home continue to pound night and day, thus keeping those badly in need of sleep from resting. The engineer promises to look into this matter and to report later. He answers the dietitian's comment relative to her gas stove by saying that company inspectors have been summoned and that a further report will be given at the next meeting. He states that the refrigerator to which reference was made by the storekeeper has been adjusted and is now cooling properly.

Credit Worker Makes Her Report

The credit worker is next introduced. She is apparently much concerned about whether parents of children detained in the hospital beyond the usual time because of quarantine should be required to pay for their board during this stay. The superintendent remarks that since it was not the fault of the parents that a quarantine arose, any charge for a stay beyond that which would have been normally required shall be franked.

She reports an interview with an irate staff member who complained that a recommendation which he had made in regard to the fee to be charged his patient was ignored by the credit worker. She presents evidence to show that the doctor's recommendation was too low and states that the patient was satisfied to pay more. The superintendent commends her upon this stand and confirms this procedure as a future policy. She remarks upon the growing popularity of private rooms in the five dollar range. The superintendent comments on the plans of the board of trustees to reorganize a hospital wing so that during the coming winter more rooms of this type will be on hand.

The credit worker apparently also is concerned about the growing tendency of staff men to refer cases to the dispensary for special studies, these patients immediately returning to the doctor's office once this work has been done. The superintendent asks the social service worker, the chief nurse and the chief resident physician for their opinion on this matter. It is finally concluded and the rule announced by the executive that such patients should be referred directly to the department in which the service is to be performed and that the credit worker alone, or in conjunction with the department head concerned, should set the rate for the study to be made.

The credit worker also presents figures covering the past fortnight showing that many ward patients pay in full for their first week's care and then finding others in the ward who pay less or pay nothing report that they are unable to pay the agreed fee for their second or third week's treatment. The question of separating all full ward pay cases from others is commented upon by the superintendent and an announcement is made that a committee of the board of trustees is considering the establishment of a full pay medical and surgical ward. The chief resident interposes a remark to the effect that he is passing upon all free cases and that no one is admitted in advance of his turn on the waiting list unless some surgical emergency is present.

There having been so many important matters presented at this meeting, the superintendent announces that on the coming Monday another staff conference will be held. He reviews the work of the morning, answering questions that have been asked and endeavoring to make more definite the details of some of the new projects presented during the meeting. He asks each one to whom a task has been assigned when he will be ready to report and the stenographer sets down the reply. This information she will use in preparing the agenda for the next staff meeting.

To Meet Again Next Week

The superintendent promises to visit several departments — the kitchen to inspect gas ranges, the storehouse to check on the adequacy of ice boxes and the wards and office of the social service department to verify the need for necessary physical repairs there. He instructs the secretary to send notices to department heads as to the tasks assigned to them. He congratulates his official family upon their unceasing endeavors in the cause of the hospital. He announces that the chief nurse's request to be absent at a national convention has been approved, the board of trustees paying her expenses and that the hospital is to participate in the clinics of a national surgical association meeting in the city soon. He then dismisses the group, thanking them for their promptness in attending and remarking that he looks forward to the pleasure of again officially meeting them a week hence.

PLANT OPERATION • • • •

Conducted by John R. Mannix and R. C. Buerki, M.D.

Without Benefit of Middleman

By Robert Warner

Superintendent, Deaconess Hospital, Spokane, Wash.

Here is a hospital that comes close to achieving that "sufficient unto itself" feeling, with its thousand acres of farm lands, its herd of cattle, its poultry and pigs, its knowledge that from the farm will come daily fresh meat, milk, butter and eggs to feed 300 people three times each day

AN INTERESTING experiment has been made by the Deaconess Hospital, Spokane, Wash., in producing some of its basic supplies on farms operated under the management of the superintendent and board of directors.

Some ten years ago the superintendent secured from Mrs. Ella Letterman Lanning, on the basis of annuity payments, 1,000 acres of the rich Palouse Creek farm land near the city of Pullman, the seat of the state agricultural college. It is about seventy-five miles from Spokane, with a paved highway most of the way, and a fine gravel highway the balance of the way, passing through the farms.

The value of these lands was appraised and the hospital issued its annuity bond to the owner, paying on the basis of 6 per cent for some and 7 per cent of the appraised valuation for the balance of the land. This is divided into monthly payments so the annuitant receives at the present time $400 a month cash for which she has deeded over entirely free of encumbrance this large tract of land. Besides this, Mrs. Lanning is contributing about $100 a month to the hospital's endowment fund.

Two hundred acres of the farm is heavy bottom land extending for two miles up and down Palouse Creek, which passes about midway through the farm. The higher land on either side is used for wheat and other grains. From these fields we have harvested from forty to fifty bushels of wheat per acre. The first year we marketed our wheat crop at $1.32 a bushel. Later the price of wheat began to slip rapidly downward. We still continued to harvest and thresh about eight to ten thousand bushels a year, but began using it to feed live stock.

We have an excellent farmer. He and the hospital jointly own the farming outfit: thirty head of large Clydesdale draft horses, weighing from 1,600 to 1,800 pounds each; a combined heading and threshing machine, the propelling of which requires twenty-four head of horses. About twenty-five acres or, approximately, a thousand bushels of threshed grain is a day's work for this machine, which requires five men to operate it. Trucks receive the threshed grain direct from the machine and carry it in tight truck beds to the warehouses on the railroad a few miles distant. One elevator has been constructed on the farm into which we put about five thousand bushels a year.

When the depression began to bear down on us and farm products rapidly lost their value so that farm owners could not meet their bills for hospital care, we conceived the idea of taking as payment such things as they had which we could use to advantage—cows, young stock, hogs, posts, lumber and poultry. We specialized in two: cattle and hogs. Hundreds of hogs have been produced on the farm. Some were

This herd of cattle is a group of hospital bills and represents about 100 head picked from the farms.

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* Parts loose... poor insulation... high maintenance... low refrigeration output... excessive current costs... abnormal heat leakage... fluctuating temperatures... high running time... leaky piston rings... worn belts—or whatever the cause of the sick, rundown condition of your equipment—a trained G-E "doctor" of refrigeration will give you the correct diagnosis and prescription without cost or obligation. This free survey service is at your disposal through the G-E Refrigerator Distributor in your territory, or write direct for full information. General Electric Co., Commercial Refrigeration Div., Sec. CX-9, Nela Park, Cleveland, O.

GENERAL ELECTRIC

Part of the farm's horse power is shown above and on the left are seen two fine young polled Angus sires.

sold in the open market, others, the choicest, we have had processed by the meat packers and manufactured into ham, bacon and lard, at a cost of $0.025 a pound. Thus we have secured the finest quality of these products.

The cattle pictured on the previous page are hospital bills and represent about one hundred head of cattle just as they have been picked up from the farms by the hospital truck. The meadow surrounding them is a small section of the two-mile area up and down this stream, while the rolling hills beyond indicate the character of the grain fields. The large hay stack at the left carries about two hundred tons of hay for winter use. These cattle are mostly cows and heifers.

In order to transform the offspring of these into a high type of beef cattle, we purchased two registered sires of the polled Angus breed. These are a low-built, blocky heavy type of beef animal, as shown by the picture. Crossing these with our herd we have secured wonderful results from the large shorthorn cows, on down through the whole herd. Every calf is black and without horns and a fine type of beef animal. Some of these calves from the short-horn cows at seven and eight months of age weigh up to six hundred pounds, live weight.

We recently arranged with a packing house in the city to slaughter and process thirty-five head. These were delivered from the herd taken as calves from their mothers. When the packer saw them, he said, "These surely are yearlings and we must charge a higher price for processing." So they classed all but a few of these calves as yearlings, though they were a little more than six months old.

For two years now the farms have furnished us all the beef we need to feed our family of 300 people. Not only is this a great saving in the operation of the hospital, but we are getting the finest type of beef and pork.

In connection with our farming operations, two dairies have been developed, one of which, with thirty cows, furnishes us fifty gallons of milk daily. This is delivered to a local dairy in exchange for their pasteurized milk, on an exchange basis of two cents a gallon. The other smaller dairy has twenty-five cows and furnishes eight to ten gallons of 33 per cent cream daily.

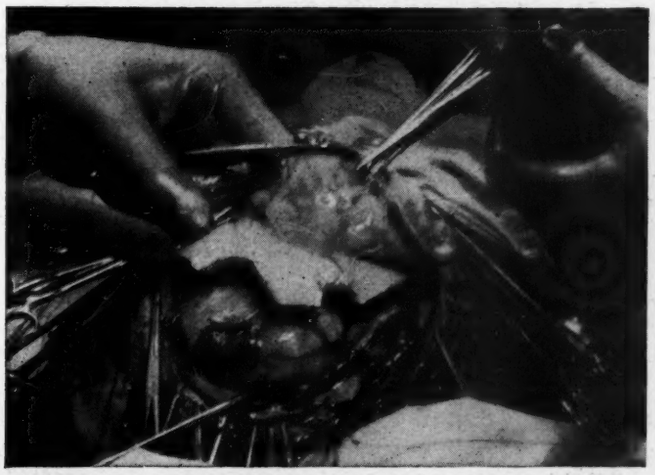
With this it has been profitable for us to put in an ice cream plant and we produce an ice cream which seems to be much more popular than any blend we can buy. We can serve it in abundance and as often as people desire, for the cost is little, though it consists of about 100 per cent cream. We are now thinking somewhat of developing one large dairy of about one hundred Guernsey cows of heavy production to take care of our milk, cream, butter and other dairy products. These items, if purchased, would cost the hospital about $1,300 a month, or more than $15,000 a year. Adding to this our beef, pork, poultry and egg supply it would amount to about $25,000 a year.

Our farmer provides all the labor, while the hospital furnishes the land and it is operated on a fifty-fifty basis. With prices of beef and dairy products mounting, we can see great possibilities for the future.

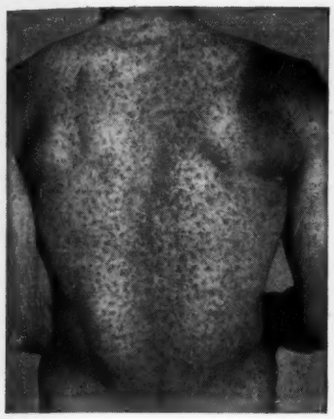
This farm could not be duplicated, perhaps, by many hospitals; but it has certainly proved a great achievement for us.

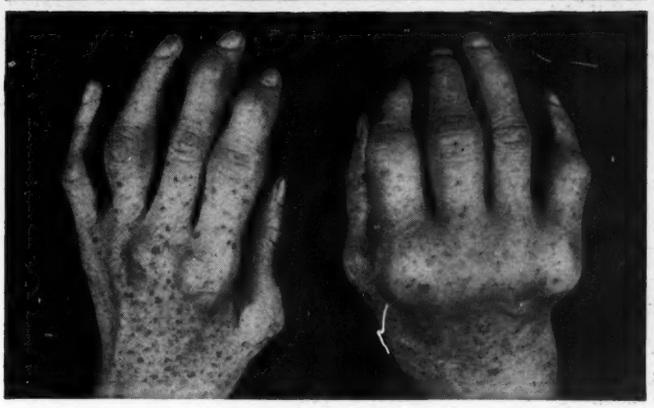
MEDICAL PHOTOGRAPHY

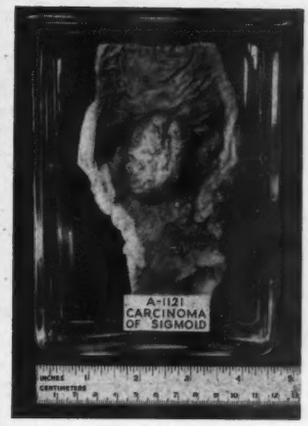
Serial photograph depicting one stage in operation for brain abscess.



Photograph of a skin disease, showing the general distribution.







Photograph of a specimen, showing carcinoma of the sigmoid.

Photograph of the hands, showing arthritic enlargement.

a simple procedure... at low cost

The Eastman Clinical Camera Outfit includes: 5 x 7 Camera with flexible stand, f.7.7 Kodak Anastigmat Lens, Compur Shutter, Graflex-type Focusing Hood. Also an Enlarging Back, Lantern Slide Back with plate holder, two Kodaflectors—lighting units. The price, $155.00.

THE Eastman Clinical Camera Outfit makes graphic medical recording convenient...inexpensive. It fills every need in "still" clinical photography.

Photographs of body surface lesions, abnormalities, operations, gross specimens...enlargements...copies of radiographs, charts, etc...lantern slides—all can be made quickly by simple, standardized technics.

Case histories which incorporate such photographs are more incisive than written records alone...of far greater legal value. Illustrated lectures and scientific papers are much more illuminating.

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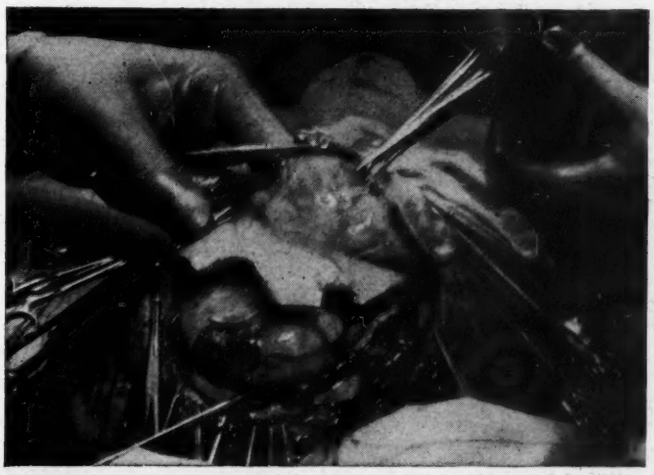

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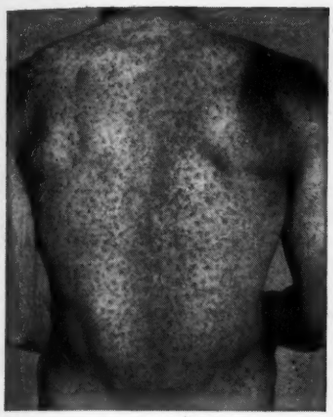

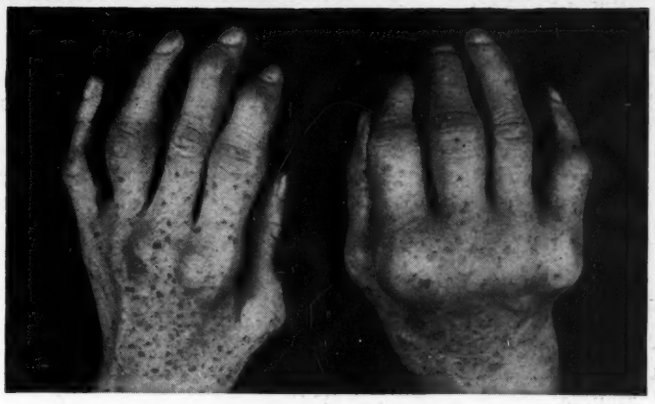

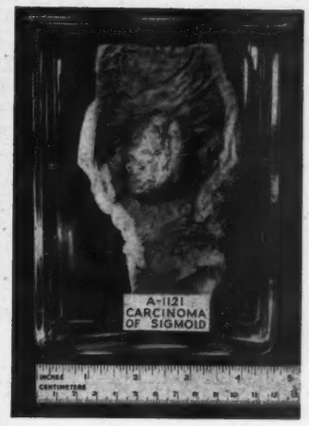

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A "Use by the User" Test

By E. Stagg Whitin

President, Associates for Government Service, Inc., New York City

The story of 192 hospital sheets of twenty-four different brands that journeyed through sixty-five launderings

THE Associates for Government Service, Inc., some years ago formed a committee on institutional supplies which was associated with the institutions under the control of Westchester County, New York. This committee undertook a study of institutional sheets, the results of which have recently been made known.

The Cotton-Textile Institute, with its sheet committee representing the whole industry, agreed to supply the necessary sheets for a test, keeping the control numbers of these sheets as a guarantee that all producers would have fair play. The test was made at Grasslands Hospital, Valhalla, N. Y. The National Laundryowners Association was asked to investigate the hospital's laundry equipment and suggestions were made as to the adjustment of the laundry facilities, already good, so as to make them specially suited for a test in ordinary washing.

The sheets were put through sixty-five launderings. A record was kept of breakage of the sheets and preliminary, intermediate and final tests were conducted by the Bureau of Standards of the U. S. Department of Commerce.

24 Brands Chosen

Twenty-four different brands of sheets were selected for this test from well known representative brands on the market. Care was taken to see that the brands chosen were representative of the five different constructions of grey goods usually used for bed sheets. The grey goods constructions were, in terms of thread counts, 72 by 72, 68 by 72, 68 by 76, 64 by 68 and 64 by 64.

When the nine sheets of each brand so selected were received from the manufacturers, each sheet was carefully measured for length and width. One sheet of each brand was then sent to the Bureau of Standards where further measurements were made of thread count in warp and filling, the weight in ounces per square yard, percentage of finishing compound, yarn size in both warp and filling, percentage of crimp in both warp and filling, breaking strength (grab method) in pounds per inch of warp and filling, stretch at breaking point in percentage in both warp and filling and the tear in pounds in both cloth and selvage.

The other eight sheets of each brand were then put into use and received no different treatment from the regular sheets of the Westchester County institutions except that during certain specified times the sheets were removed from service in order to be remeasured. As soon as these measurements were completed, the sheets were put into service again.

After over four years constant use in these institutions, during which time each sheet received sixty-five washings, measurements were taken again. A comparison was then made of these measurements with similar measurements taken when the sheets were received from the manufacturers before they were washed or put into service. This comparison reduced to averages for each of the three classifications based upon the grey goods construction revealed the following:

At the conclusion of the test all of the sheets placed in the test were still in use at Grasslands with the exception of those withdrawn from time to time and sent to the Bureau of Standards for measuring breaking strength and thread count. Even sheets torn by catching on the bed springs were repaired and returned to service at the institution.

While it is true that the 68 by 72 construction, regularly purchased by the United States Government on specification of various departments and bureaus, will probably meet the needs and service requirements of most institutions, it is noteworthy that lower constructions down to 64 by 64 can be counted upon to give good service when budget limitations do not permit or other considerations do not require the purchase of the better and heavier muslin sheets.

It is generally recognized that percale sheets manufactured of high count, fine grey goods, though not included in these tests, have certain advantages over those lower count or heavier goods. The higher the thread count in a sheet, the finer the yarns that are used and the closer together these yarns are laid, the lighter the sheet will be and the better the appearance and feel to the hand. Such sheets are usually higher in price, however, than the coarser sheet.

The U. S. Department of Commerce calls attention to the following: So far as durability is concerned, all of the types of sheets tested seemed equally satisfactory. The cost of laundering a sheet through its life is several times the original cost and is dependent upon the weight of the sheet when laundering is paid for on a weight basis. The difference in cost of laundering an expensive lightweight sheet and a less expensive heavyweight sheet may more than overbalance the difference between the original cost of the sheets, or in other words when the cost of laundering is considered the higher priced sheet may be less expensive.

During the past four years sheet manufacturers may have developed new brands of sheets which it was not possible to include in these tests on an equitable basis. The data given here must therefore not be construed as applying to these later developments.

Decrease in Length Noted

It was found that all sheets decreased in length from 7 inches for the 64 by 68 grey goods class to 7¼ inches for the 68 by 72, 68 by 76 and 72 by 72 grey goods class, the greatest single decrease in length coming after the first washing.

An increase in width of approximately 2¼ inches for the 68 by 72, 68 by 76 and the 72 by 72 grey goods class, to 2¾ inches for the 64 by 64 grey goods class occurred concurrently with the decrease in length.

It is therefore apparent that a purchaser of sheets can expect a decrease of 7 to 7¾ inches in length of a 108-inch torn length sheet after many washings with a corresponding increase in width of 2¼ to 2¾ inches. (It should be here noted, however, that the sheets were fed into the mangle widthwise rather than lengthwise thus giving this result.)

It was also found that there was a decrease in the number of warp threads per square inch and an increase in the number of filling threads per square inch giving a slight increase in the sum of the warp and filling threads per square inch.

After several washings, all finishing compound disappeared and the weight of the sheets in ounces per square yard therefore decreased. In other words, the sheets became softer by long use and the consequent washings.

There was a loss in breaking strength of 53¼ per cent in the better sheets, 53.8 per cent in the 64 by 68 and 54 per cent in the sheets made of the 64 by 64 grey goods.

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If you will write to us and tell us who you are and what you've done and what you'd like to do . . . if you will sit and write it like you'd write to an old friend . . . *we* will help you to find the job you want to find.

It may be that the work you are doing today *is* "the finest job in the world"; maybe it is and you haven't given it a chance, haven't put into it all of the earnestness and fire and fight that makes most *any* job fine.

But, if you *have* done the best you know how to do, if you *still* want a better job, a different job, an OPPORTUNITY to work in a job you'd love, then we suggest that you write to us, write as though you wrote to an old friend.

You see, *other* individuals and institutions come to us *constantly* hunting for *you*. They ask for smart and earnest people, for physicians and surgeons, for graduate nurses, technicians, dietitians, for *every* type of hospital worker . . . and *we* find the ones they want.

Maybe *you'd* be happier in one of our positions. Maybe you'd love life more, do finer work. Write to us. We'll surely help you to find out.

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Medical Supervisor

The school of the university hospital offering this position was discontinued two years ago; it may be re-opened in the near future, however. The supervisor should be a college woman with special work in medical nursing and experience in teaching and supervision.

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Surgical Nurse

In 1930 we placed one of our capable nurses in charge of surgery in a small, well-equipped hospital. Now she is to be married and we must find someone to succeed her. A delightful place—fine tennis courts—nine hole golf course—surrounded by great mountains. The physician in charge is chief surgeon to several large companies. The duties, therefore, include complete charge of his personal affairs; hence, the applicant must take dictation and type proficiently. The salary is one hundred thirty-five including maintenance. If you qualify, write and we'll tell you more about it.

●

Superintendent of Nurses

The administrator—a highly regarded physician—of one of the country's leading hospitals is looking for a capable executive to serve as his director of nurses. His crying need: ability to discipline a staff of one hundred fifty graduate nurses.

●

Read the classified columns of THE MODERN HOSPITAL for MORE of our opportunities.

The amount a sheet would stretch, warp or lengthwise, before breaking was found to increase about 4 per cent by use but it was also found that a sheet lost about 5 per cent of its ability to stretch before breaking in the filling or crosswise direction.

The resistance to tear in pounds was reduced 63 per cent in the cloth and 50 per cent in the selvage by the amount of use and washing.

It is apparent that a purchasing agent can be governed in his purchase of sheets by the character of his clientele and the price best fitted to his requirements. If he is purchasing for a private institution, he may wish to specify a fine count sheet with a good feel to the hand, while if purchasing for a charitable institution, he will probably specify a lower grade or coarser sheet.

Other conclusions of the study are:

First, the use of these sheets was naturally associated with beds and it was found that the life of the sheet not only was affected by the size of the sheet conforming to the size of the bed but was dependent upon the condition of the bed; and that the sharpness of the corners of the bed, the protrusion of any loose wires or other breakage obviously increased the wear as well as made rents in the sheets. Thus a simple, obvious deduction is that a factor in the use of a commodity must be the condition of the other articles used with it, and its length of life is dependent upon this factor.

Second, while the bed remains the same size, sheets change. Putting the sheets through a mangle tends to increase the size of the sheet either widthwise or lengthwise according to the way in which it is fed into the mangle.

Thus we have not only what is normally referred to as shrinkage, which may not be ordinary shrinkage at all, but the pulling out of the sheet as the result of the washing process, which tends to cause contraction in one way with expansion in the other. The technique of alternating from widthwise to lengthwise in feeding into the mangle would overcome this difficulty. Institutional mangles range from 100 to 110 and 120 inches in width and the latter two permit lengthwise feeding.

Third, probably the most interesting result or finding was entirely outside of the test. It is known that manufacturers change their specifications from time to time and that with a varying price a fixed standard of goods may be maintained. Thus the Westchester test, continuing for several years, applied only to the sheets which were put in the test; while by the end of the test practically all the manufacturers had either changed the specification upon which they put their brand name or had changed their brand name using a new specification. Therefore, if the test had proved that a certain brand was inferior to another brand, it would give no basis for contending that those conditions still prevailed.

While it is the manufacturers' custom to change their specifications it became apparent that the fact that real tests were being made gave a stimulus to new and relatively improved specifications and that the continuance of "use by the user" tests will tend to lessen the shifting of specifications.

A practical deduction from this test is that if a "use by the user" test is to be of immediate use and serviceability to the buyer, the life of the commodity tested must be so brief that the test will be completed while goods of the same specification can still be obtained from the manufacturer.

Ways to Maintain Varnished Furniture

Maintaining the luster and finish on varnished furniture is not a difficult problem and simply requires a periodical washing with a mild soap, using lukewarm water and clean cloths, says Dr. G. Otis Whitecotton, administrative assistant, Alameda County Institutions, Oakland, Calif. Frequent polishing with a good grade liquid polish, applied sparingly, and followed by a brisk rubbing with cheesecloth to remove excess oil, will keep the surface in good condition and with a pleasing appearance.

Deep scratches and checked areas should be repaired by professional polishing or finishing firms.

The use of solutions high in alcohol content is an everyday hospital routine and the occasional accidental spilling of such solutions on varnished furniture with consequent destruction of the finish presents a real problem. However, this situation may be satisfactorily met by the use of the following formula which will give surprising results if properly used.

Cleaner

Denatured alcohol	12 ounces
Turpentine	2 ounces
Benzol	2 ounces

Finish

Paraffin oil	10 ounces
Turpentine	2 ounces
Cider vinegar	2 ounces
Japan drier	2 ounces

Shake the finishing mixture well before applying and use an unwashed cheesecloth sugar sack to clean and polish.

THE HOUSEKEEPER'S CORNER

• The first meeting of the new executive board of the Connecticut chapter of the National Executive Housekeepers Association produced many suggestions of a constructive nature for programs during the coming year. Definite arrangements will not be made however until the regular meeting to be held September 19. Those attending were: Blanche Newton, Grace Hospital, president; Mrs. Gertrude Page, New Britain Hospital, first vice president; Evelyn Coolidge, New Haven Hospital, recording secretary; Mrs. Catherine Mason, Norwalk Hospital, corresponding secretary; Mrs. Katheryn Quinn, Norwich State Hospital, treasurer, and Miss Amy Harris, Long Lane Farm School, and Mrs. Gladys Hancock, Sterling Nurses' Dormitories, New Haven Hospital, executive board members.

• An attractive decorative scheme for the children's ward was discovered at St. John's Riverside Hospital, Yonkers, N. Y. Blue, peach and ivory are the colors used. The walls are ivory with a light blue band around the top next the ceiling, outlined in rows of silver stars. Aside from their decorativeness, the stars give the small patients something to look at. Hangings at the windows are peach and the beds are painted in blue mixed with aluminum, rendering a silvery effect. The chairs, too, are blue with peach pads.

• The hospital field was well represented at the class in housekeeping held in July at Cornell University. Connecticut was particularly conspicuous with three members on hand: Evelyn L. Coolidge, New Haven Hospital, New Haven; Catherine M. Mason, Norwalk General Hospital, Norwalk, and Blanche I. Newton, Grace Hospital, New Haven. Other hospital women who studied under Mae E. Scharlin, executive housekeeper at the Ten Eyck Hotel, Albany, N. Y., were: Myra B. Dibble and Aimee H. Sheets, Overlook Sanitarium, New Wilmington, Pa.; Jean M. Hall, Pottsville Hospital, Pottsville, Pa.; Mary Schaeffer, Tompkins County Memorial Hospital, Ithaca, N. Y.; Florence E. Walker, Wilson Memorial Hospital, Johnson City, N. Y., and Caroline B. Jennings, St. Barnabas Guild House, Lakeside Hospital, Cleveland, Ohio.

• "A keen observation and a notebook are the housekeeper's companions on her daily rounds," says May Middleton, superintendent, Methodist Episcopal Hospital, Philadelphia. "A leaky spigot adds to the water tax, a roughened chair round tears silk stockings, a squeaky hinge wakes a guest, a dusty corner denotes a careless maid, an unrepaired rip in the draperies or sheets increases the furnishing cost, rough linen means sore elbows."

Buying by Specification

By G. W. Olson

Assistant Superintendent, Los Angeles County General Hospital, Los Angeles

QUALITY as applied to a manufactured article embraces not only the elements of genuineness, purity, solidity and durability, but also the important attributes of design, workmanship, and suitability or fitness. A surgical instrument, for example, may be made of the finest steel, glistening with the purity of its rustless alloys, solid and durable under the severest test, yet it may be faulty in design and defective in workmanship, with the result that in the surgeon's hand it becomes awkward and unserviceable.

The true order in which a buyer should look at the characteristics which go to make up the value of whatever he buys is: (one), quality, (two), service, and (three), price. An authority in the field of purchasing makes the following statement: "Many will no doubt question the correctness of putting price last, especially as it is so contrary to the general way of looking at these things; but how can it be put first if so doing results in one's failing to get the service one needs? It is no good buying a thing and not getting proportionate returns for what is spent. If price is put first, quality and service must be secondary."

Not Quality Conscious

Hospital superintendents or their buyers have not always been quality conscious, however, if one may judge by the heaps of nondescript equipment and furniture of iron and wood which clutter up hospital basements and attics and the truck loads of rusting and leaking utensils hauled to the dump every year.

The only safe and sure way to purchase equipment and supplies of quality is to buy by specification. Not even buying from sample is safe, unless a complete and honest specification accompanies the sample. Such specification should describe in simple language the material used, the method or process of manufacture, the character of finish and how it should be applied. An unqualified guarantee from the manufacturer as to quality and serviceability should be required.

The specification for any article to be specially built should provide for inspection and testing, to be done by the purchaser or his representative, and replacement of any article not measuring up to the requirements, with a continuing service and replacement guarantee for such period of time as may be deemed appropriate, varying according to the nature of the equipment and the manner and purpose of its use. If an article of original design is ordered, or an existing type is materially altered, a detailed drawing should accompany the specification and be made a part of it. When possible this drawing should contain in plain figures and words all essential details pertaining to dimensions, material, fabrication and finish, so that a factory foreman or mechanic may comprehend at a glance what the written specification covers.

Your reaction may be that such methods are too complicated and expensive for the average hospital which buys relatively small quantities of any single item except in cases of new extensions or extensive refurnishing. My answer is that if you buy only a single item, be it a bed, a bedside stand, a mattress, a bedside utensil, a chair, a scissors, a needleholder or an artery forceps, you cannot afford to buy without knowing what you are getting.

Nothing Mysterious Here

There is no mystery or magic about a specification. It is only putting into writing what you would say to a craftsman to whom you might go to have the thing made that you need or want. By writing out these instructions and furnishing a sketch or picture, with measurements plainly indicated, you are giving all craftsmen or merchants whom you trust well enough to have them supply the thing you want, an opportunity to quote you their prices on an equal basis.

Such a specification, or any specification no matter how elaborate, does not, however, magically produce just what you want exactly as you want it; provisions must be made for inspection and testing, and a checking of materials and workmanship to ascertain if they conform to requirements. Add to these measures of assurance a guarantee of quality and service and you can be reasonably certain that you will get what you bargained for.

No hospital equipment from which a long period of satisfactory use is expected should be bought without a specification, either your own to be followed by the manufacturer, or the manufacturer's to be fully understood and approved by you. If your dealer cannot give you a true description of the article he is offering to sell you, it is best not to make the purchase until he has obtained this essential information for you. There are reputable makers of every line of equipment and supplies used by hospitals and they invariably print some kind of specification of their wares. It is necessary, however, in order to be absolutely certain that an article built to that specification possesses quality, to check the specification with someone who knows materials and processes, or against some specification which has proved adequate, or to obtain a sample and put it to severe tests.

Design is an important element of quality in some articles, not so much from the esthetic standpoint—although that, too, is important—as from considerations of fitness or serviceability. Certain surgical instruments are so designed that the handle rings of forceps or clamps come from ⅛ to ¼ inch closer together when the instrument is clamped than another well known make to which surgeons have become accustomed in recent years. The result of this difference is a feeling on the part of the surgeon that his fingers have grown weak or the instrument is faulty.

In bedside utensils design must be considered from the standpoint of fitness for the newer cleansing and sterilizing devices as well as the comfort of the patient. About 200 bedpans bought by the Los Angeles County General Hospital in advance of the completion of the new building could not be used there because they were too large for the built-in bedpan washers.

A fracture bed which had for years been standard in the old hospital, where wards had double doors and elevator openings were higher and wider, had to be partially dismantled every time it had to be moved in the new building. As a consequence the design of all the equipment for the new hospital was carefully studied to prevent future experiences of this kind.[1]

[1]Read at the hospital conference of the American College of Surgeons, San Francisco.

Pulpit in a New Rôle

Hospitals and clinics usually have one large lecture room or more than one. Here a table serves the speaker as a place for papers and notes. Tables are too low and little removable boxlike structures are not especially effective and often represent a contrast to the otherwise well appointed room.

The Falk Clinic, Pittsburgh, is using a standard church pulpit, finished to match the rest of the furniture. Contrary to first impression, this is ideal and entirely in keeping with the woodwork and furniture. These pulpits have an adjustable (12-inch range) support. Proper lights are available.

A standard, nonecclesiastical pulpit of excellent construction and with adjustable top can be purchased for from $25 to $35.

FOOD SERVICE • • • • •

Conducted by Anna E. Boller, Rush Medical College

A Yankee Invades a Texas Kitchen

By Frances Ross Lawler

Chief Dietitian, Baylor University Hospital, Dallas, Tex.

TEXAS has this year occupied the limelight with her Centennial celebration. While the institutions of the Southwest are commanding so much attention, something might be said of the hospital dietary departments in this section of the country.

There is abundant evidence that food service is coming to the foreground in the South. The older hospitals are remodeling and modernizing their kitchens. New institutions are placing greater emphasis on food facilities. More dietitians are being employed in hospitals. This applies, as well, to dormitories, schools, cafeterias and commercial fields. Mention should be made of the excellent home economics courses offered by Texas colleges and universities. The equipment and teaching facilities of these schools are outstanding. The new Texas Dietetic Association, organized two years ago, is proof of the enthusiasm for dietary advancement.

Much has already been written of the food problems peculiar to the South. One can only repeat that colored help, while providing inexpensive labor, requires constant and the closest supervision.

Negro chefs cook largely by instinct rather than by recipe. It is rare to find one who will conscientiously adhere to measurements and not resort to "skillets" and "scoops." It is possible to obtain good cleaners and maids, but the best require an ever watchful eye. Along with the amusing features of a happy-hearted race comes the irresponsibility that can be most exasperating at times.

It is a real experience for a "Yankee" to come South. The chief difference is the tempo at which life moves in the warm climate. The sooner the Northerner learns that it is fruitless to attempt to drive people, the more she can accomplish with the minimum of wear and tear on her nervous system. Salespeople pay their calls leisurely and pass the time of day. Tray service lacks the click and snap of departments in the North. Eventually the work gets done; maybe the Southerner has learned the secret of conservation of energy. Certainly the old tradition of courtesy still lives in the South. It is worth a great deal to hear the characteristic and oft repeated "Please, ma'am" and "Thank you, ma'am."

The Texan accepts the "Yankee" with reservations, at least until he is assured that he won't be deprived of his precious beans and cornbread. A Texan without these two foods, black-eyed peas, grits, hot biscuits and greens is an unhappy soul indeed. Southern cornbread is not to be confused with johnny cake. It is less sweet and coarser in texture—a bread intended to be eaten with meat and vegetables. They like it best thin, crisp and hot. The batter is baked in cornstick pans for the patients.

Foods as a whole and meat and vegetables in particular are good in quality, plentiful and stay in season a surprisingly long time. The larger produce, packing and grocery supply houses have hotel departments and these, of course, cater to the institutional trade.

Baylor Hospital has taken an active interest in developing its dietary department. The hospital is one of the largest in Texas and is a part of Baylor University. The school, located at Waco, Texas, was organized in 1845; it is the oldest university in the state. The medical unit was founded in 1900 and occupies the same city block with Baylor University in Dallas.

While Baylor is a teaching institution, it has a relatively small percentage of free beds. The hospital maintains a high percentage of occupancy. Capacity is 325; daily census averages 300. A new maternity building now under construction will increase the

bed capacity by 60 beds. Baylor training school for nurses has an enrollment of 150 students including postgraduates.

The dietary staff is solely responsible for the feeding of patients and personnel. Four graduate dietitians are employed. The chief dietitian purchases the food and supervises its preparation in the main kitchen. She is directly responsible for the food service for nurses and staff.

A therapeutic dietitian has charge of the special diets, which average thirty in number, and the diabetic diets, numbering around twelve. Two student nurses are assigned to the dietary department, one on special diets and one on diabetic service. The diet kitchen dietitian summarizes the food to be sent to the division kitchens and supervises the preparation of food nourishments sent the patients. A fourth dietitian instructs the colored maids in the division kitchens and during the school year teaches student nurses.

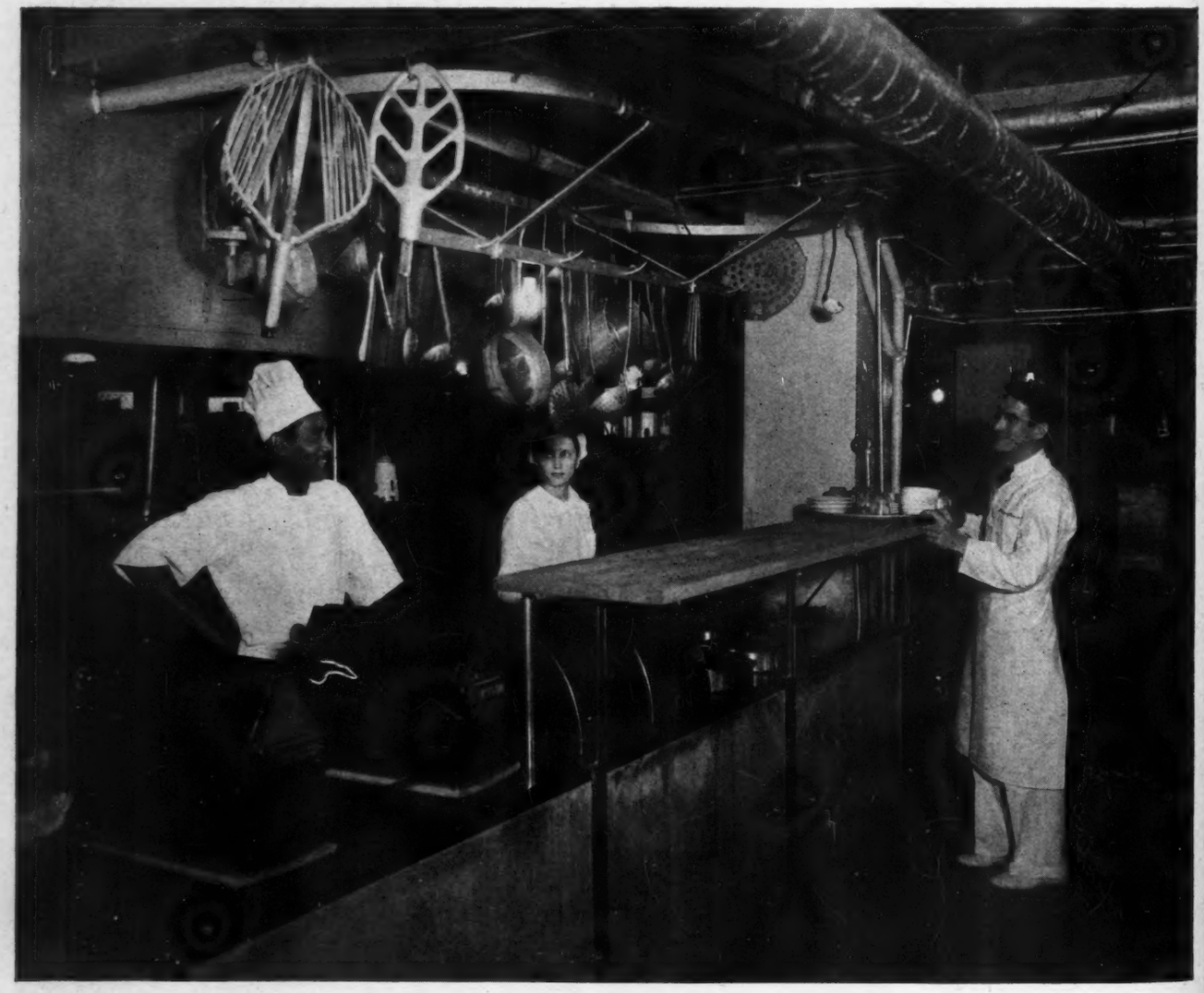
A steward checks the supplies in the main kitchen, and a night super-

BAYLOR UNIVERSITY HOSPITAL Fresh Fruit
FOOD COST

DATE	FIRM	PRODUCT OR BRAND	AMOUNT	COST	UNIT COST
4/13	Ben E. Keith	Grapefruit	½ crate	2.15	.25
4/13	" "	Oranges	2	.20	.10
4/10	Reese Grocery	Grapefruit	8	.64	.08
4/15	Sam Goodman	Blackberries	1 Box	.15	.15
4/15	" "	Plums	1½ crate	3.00	2.00
4/15	" "	Calavos	5	.75	.15
4/15	" "	Cherries	2#	.75	.15
		Sub-Total	$	86.37	
4/16	Boedeker	Strawberries	9-4 oz	4.95	.55
4/16	Sam Goodman	Grapefruit	11	.77	.07
4/16	" "	Blackberries	3 Box	.75	.25
4/16	" "	Bananas	25#	1.00	.04
4/16	" "	Grapefruit	1 Bx	4.25	4.25
4/17	Boedeker	Blackberries	1 Bx	.27	.27
4/17	Sam Goodman	Bananas	68#	2.72	.04
4/17	" "	Apples	3 Bx	7.50	2.50
4/18	Boedeker	Raspberries	1 Bx	.75	.75

Form 656-G

Food invoices are recorded daily at Baylor in a card catalogue system. Comparisons are made periodically to determine how the expenses average.



Negro chefs cook largely by instinct rather than by recipe.

TEA

Most Refreshing of All Summer Beverages

Serve it frequently—either iced or hot—to convalescents

JUST as hot tea is recognized by medical authorities as one of the finest of all beneficial stimulants, so, also, is iced tea judged by these same authorities to be one of the most refreshing of all summer beverages.

In summer, hot tea has a pronounced cooling effect; for, according to medical opinion, it actually removes 50% more heat from the body than it puts into it. This is one reason why hospitals everywhere use tea so extensively.

When patients are fretful and uncomfortable—when sultry, muggy weather saps their vitality and sets their nerves on edge—turn to tea, either iced or hot. Serve it frequently throughout the day. The magic of tea works wonders in making life more pleasant for those confined to hospital beds.

INDIA

MEDICAL AUTHORITIES APPROVE THE GOOD BLACK TEAS OF INDIA, CEYLON, AND JAVA-SUMATRA

Turn to TEA Today!

Iced tea actually lowers body temperature

Hot tea is cooling even in the hottest weather

BAYLOR HOSPITAL MENU

Saturday, July 11, 1936

Breakfast

Name..... Room.....

Fresh fruit, bananas
Wheat cereal
Bacon, eggs
Whole wheat toast, white toast
Tea Coffee Milk

Dinner

Name..... Room.....

Cream of asparagus soup
Roast veal, fried apples
Broiled sweetbreads
Parsley potatoes, gravy
Baked potato
Fresh peas
Buttered carrots
Cabbage and fruit salad
Stuffed prune salad
Maple tapioca
Vanilla wafer pudding
Whole wheat bread
White bread, cornbread
Tea Coffee Milk

Supper

Name..... Room.....

Vegetable soup
Cold sliced meat
Spaghetti and tomatoes
Southern baked hash with catchup
Turnip greens, cauliflower
Sliced orange salad
Head lettuce, French dressing
Cup cake
Canned figs
Whole wheat bread
White bread
Tea Coffee Milk

visor takes charge of the midnight meal. Three colored chefs are employed in the main kitchen and two cooks in the diet kitchen. Full-time colored help totals twenty-four. Four white regular employees work in the dining halls. Medical and dental students wait tables during meal service.

All food for patients and personnel is cooked in a central kitchen located in the basement of the nurses' residence. Private and semiprivate patients are given selection menus to check. Meat, potatoes and vegetables are cooked in the main kitchen. Selective items, patients' salads and desserts, light and soft menus, special diets and requests, and in-between nourishments are prepared in the diet kitchen.

There are nine division kitchens located in the four wings of the hospital, and one pantry in the colored hospital building. The food is routed in insulated trucks to the division kitchens where it is served from steam tables. Articles for special diet are marked with the patient's name and room number, enclosed with the menu in a metal box, one container for each floor. Only eggs, toast, bacon and steaks are cooked in the floor kitchens.

A student nurse is assigned to each division kitchen. She is responsible for making salads and for checking and serving trays. The dietary staff with the cooperation of the nursing department has recently launched a most successful campaign for more attractive salads and trays. The preliminary class in dietetics engaged in a contest to see who could produce the most appealing picture of a salad. The winner was given a decorated cake as a prize. The pictures were mounted and placed over the salad tables in each kitchen with titles such as "Let's Make Attractive Salads" or "Patients Appreciate Crisp Salads." The results have been gratifying.

Diabetic patients are segregated. The therapeutic dietitian and the nurse assigned to the service have charge of the special kitchen on the diabetic division. A sun parlor is available for ambulatory patients and for group instruction. Out-patients are served meals in the sun room.

Keeping Coffee Hot

Baylor has recently installed new equipment in the main kitchen. The coffee service for patients' trays is rather unusual. In the coffee-brewing set used, a container is provided for each kitchen. Each urn of coffee is made separately. When brewed, an electrode is inserted in the top of the urn. A carriage transports the coffee to the proper kitchen where an electric connection is fitted into the electrode. The urn is equipped with a faucet. The electrode keeps the beverage hot, and the patients' coffee pots are served individually as needed from the spigot. The beverage is uniform in quality and the common complaint of cold coffee is almost eliminated.

The patients' china is adobe ware in a colorful pattern. Every effort is made to make the trays attractive and to check them accurately. A dietitian is assigned to definite kitchens each meal; she remains on the floor until all trays are served. The keynote of the entire dietary service is close supervision.

The bookkeeping system employed is comparatively simple. As the food is ordered, it is recorded in a notebook. The kitchen steward inspects and weighs the merchandise as it arrives. He compares the invoice with the original order and approves it if it is correct. The chief dietitian rechecks each invoice before it is sent to the auditor's office. The invoices are recorded daily in a card catalogue system. Comparisons are made periodically to determine how expenses are averaging.

A bimonthly report is prepared showing the number of pounds and cases of each food commodity used, and the price paid.

Meals served over a period of nine months average 55,352 per month; raw foods cost 13.1 cents and prepared foods cost 17.6 cents. Included in this meal count are special parties. The South is socially minded; entertaining consumes a liberal portion of the dietitian's time and budget.

Once adjusted to the pace, food habits and labor conditions, dietitians fare well in the South. It is possible to accomplish much where the attitude of the people is friendly and progressive.

How to Prevent Ice Cream Shrinkage

While it is true that the government specifications for ice cream limit the percentage of overrun to 50 per cent, the general commercial practice is to produce an ice cream with 100 per cent overrun, that is, one gallon of ice cream mix makes two gallons of ice cream. As a matter of fact ice cream made of pure ingredients and 14 per cent butter fat, and made with 100 per cent overrun is excellent.

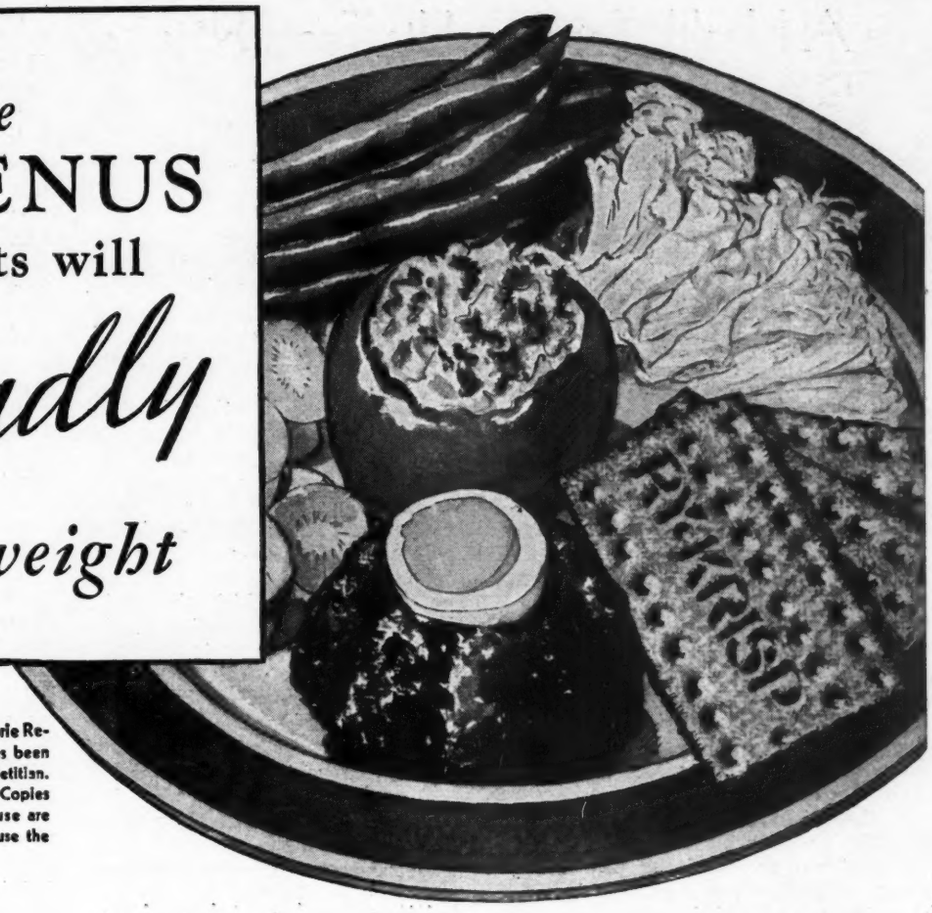
The difficulty arises when the ice cream is scooped out for serving. Because the ice cream in the serving cabinet must not be too hard to handle easily the mere process of scooping it out greatly compacts the ice cream and it loses much of its bulk. In a recent test a quart of ice cream actually yielded only six scoopfuls instead of the sixteen that had been expected. This was not only due to compacting the ice cream but also to giving too much on the edges of each scoopful.

Experience shows that this large loss from ice cream shrinkage may be prevented by having the ice cream pre-packed in paper containers ready to be served or by serving slices of brick ice cream. This type of service will reduce the total cost per serving of ice cream by nearly half. This means that hospitals can afford to serve ice cream much more frequently.

All About Vitamins

Suggested lesson plans on Vitamins A, B, C, D, E and G have been prepared by the Educational Department, Wisconsin Alumni Research Foundation, Bascom Hall, Madison. These are most helpful in teaching classes in nutrition, health, home economics and agriculture. Included are photographs illustrating the effects resulting from a lack of the various vitamins, a comprehensive bibliography, recent literature on vitamin research and clinical data. Numerous teachers and several home economics authorities collaborated with the foundation.

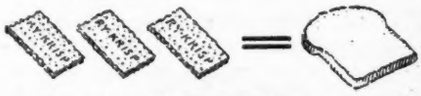
Here are MENUS your patients will follow *Gladly to lose weight*



A complete program of Low Calorie Reducing Menus for One Week has been planned by a well-known dietitian. A typical dinner is illustrated. Copies of these menus for your own use are available upon request. Simply use the coupon below.

Ry-Krisp, used in place of heavier starchy foods, serves an important double purpose in moderate reducing diets.

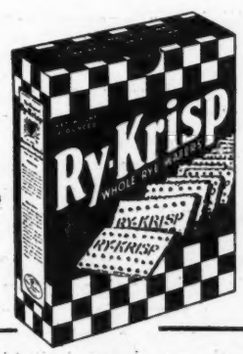
FIRST: It provides bulk to give a sense of repletion with relatively low caloric intake—because Ry-Krisp is simply whole rye, salt and water—double baked. Each crisp wafer supplies only 20 calories. Each one is capable of absorbing 5 times its own weight in water. Moreover, due to its high pentosan and fiber content, 12% of the total carbohydrates in Ry-Krisp are not assimilable.



It takes *three* RY-KRISP Wafers to equal a single slice of bread in caloric value.

SECOND: Ry-Krisp makes it easier for the patient to forego other foods you may prohibit, because it tastes so good. Its crispness and unique whole rye flavor make it tempting, pleasing in itself—a delightful accompaniment to any foods the diet may permit. Served as toast for breakfast, crackers or bread at lunch or dinner, it replaces prohibited foods naturally and pleasantly.

For free samples of Ry-Krisp, the Research Laboratory Report and the Low Calorie Menus for One Week offered above, use coupon.



RY-KRISP
WHOLE RYE WAFERS

RALSTON PURINA COMPANY, Dept. MH, 177 Checkerboard Square, Saint Louis, Missouri

Please send me, without obligation, samples of Ry-Krisp, a copy of the Research Laboratory Report, and the Low Calorie Menus for One Week.

*Name*_____ *Address*_____

*City*_____ *State*_____

(This offer limited to residents of the United States and Canada)

A Health Team and Its Team Play

By Josephine Taylor

Medical-Social Worker, Cook County Hospital, Chicago

A CLINIC dietitian who wrote in 1921 said that the work of the visiting housekeeper, the social worker and the hospital dietitian, if not unified and correlated, is like a broken telephone wire which expends its force in the air.

Certainly in the past years all the professional workers concerned with the treatment of the patient have grown to realize that they are parts of one organization, directed by the doctor for the welfare of the patient, and that team play between these parts is necessary if the goal is to be effectively reached. Doctor, nurse, dietitian and social worker are growing to be more interdependent, in fact, more truly a health team.

Margaret Byington states that team work may be considered to involve three elements—first, a common purpose recognized as being such; second, the utilization of the experience and ability of each member of the team with a recognition of the real value resulting from such variety of experience, and third, a good technique of collaboration. She sets as our common goal a better life for those individuals and families known to us and the development of more adequate community resources.

Two workers may set different values on the immediate social objectives, but these differences may be resolved in terms of the larger purpose if mutual confidence is felt in the aims and techniques of other workers and if a willingness to further the purposes of their professions is indicated.

The boundary lines of the responsibilities of dietitian and social worker overlap and interweave, causing an interdependence which occurs not only in the early stages of the patient's treatment but continues throughout because of the social problems constantly arising and affecting the work of the dietitian. Each group should have some understanding of the work and skills of the other.

Essentials for Good Team Work

It is thought that if the dietitian were given some general training in the fundamentals of social work, and the social worker given some knowledge of the part played by food in health and disease and of the fundamental aspects of dietetics and nutrition, the results would be advantageous. Without this knowledge, social problems may slip through the dietitian's fingers and situations with a definite food significance may escape recognition by the social worker. Mutual understanding coupled with knowledge, added to the common goal, takes us two-thirds of the way to good team work.

Technique in collaboration, the third element in team play, is a practical necessity in these days of heavy patient loads. A common goal and the understanding of each other's functions may mean little if hit-and-miss procedures cause innumerable irritations and frustrations.

The methods by which the social worker sends her information to the dietitian, the arrangements for conferences, the clear division of responsibility—all are procedures that should be worked out cooperatively and adhered to except in cases of emergency. If routine procedures are well formulated and faithfully followed, the system will be able to permit flexibility enough to care for the exceptional case in a special way without disrupting the clinic's functioning.

Dietitians and social workers have a common goal and are gaining in the ability to recognize and utilize each other's skills in attempting to reach it.

In outlining a program of health education let us consider first what the social worker's share in the general nutritional program can be, going on later to the cases where special diets are required.

The dietitian needs as clear a picture of the life and home surroundings of the patient as possible. For the patients in the general class in nutrition she may not want a long case history, but rather a thumb-nail sketch from the social worker, which may help her in adapting the class work to the needs of individuals or families.

It has been said that the personality of the patient has to be reckoned with in nearly all medical processes except the laboratory. Especially in the field of nutrition is the personality of the patient important, since personal experiences, family training, racial and religious habits are all bound up in the subject of food. By forewarning the dietitian of prejudices and other personality traits the social worker may prevent the patient from assuming negative attitudes toward the food clinic and becoming "uncooperative"—that old tag too apt to be given to all patients who do not fit into accepted patterns.

If the hospital or clinic social worker knows the patient first, and has become to him an accepted and reliable guide, she may do much by giving the food clinic her stamp of approval, offering it as one of the privileges of the dispensary. Care, of course, will need to be taken not to insist upon attendance at the food class so that it become a pill that must be taken.

Preparing the Patient

The dietitian's job can be facilitated by the social worker from her first contact with the patient. The doctor and the social worker, by making the patient a partner in his treatment up to the limit of his understanding, can pave the way for the dietitian. The physician and the social worker will need to tell the patient a good deal about his illness, sketching the plan of treatment and what is to be done first. By relating the plan of treatment to the patient's way of life and helping to work the two out together, the social worker shows him that modification of his scheme of existence may be possible.

When this has been begun, changes in the food habits of the entire family may be brought about without too great a readjustment of the patient's beliefs. Part of the job of both social worker and dietitian is to institute measures which will not only help the patient to become well and stay well, but will help the rest of the family to attain health. The dietitian is anxious to find out which patients are willing to "work for their health," as one dietitian has put it, and I believe that the social worker can help to develop in the patient attitudes of participation in his own treatment which will develop more of these "workers."

In her interpretation of the nutrition class, the social worker needs to strike a nice balance between making the feeding of a family seem to be a challenge, a job worthy of intelligence, interest and application, and yet avoiding discouraging the patient or the mother who feels herself inadequate for the task.

To the thwarted, ambitious person who needs new channels in which to excel, one approach will be stressed, while to the person who feels inferior and has a defeatist attitude, more encouragement will be given. In her response to the patient's revelation of his interest in the food class, by her interpretation to him of points that he brings up for clarification, the so-

KARO
BEFORE AND AFTER OPERATIONS

WATER BALANCE (24 HOURS)	
Intake	*Outgo*
Drinking Water (600 cc.)	Urine (800 cc.)
Beverages (600 cc.)	Skin (700 cc.)
Solid Food (700 cc.)	Lungs (600 cc.)
Metabolic Water (300 cc.)	Feces (100 cc.)

SURGEONS prepare patients pre-operatively to prevent acidosis and post-operatively to protect nutrition. Karo serves this dual purpose. Given with a soft diet before operation the patient will better resist surgical acidosis. And Karo forced with fluids after operation provides vital energy the patient craves.

Acidosis accompanies anesthesia and toxicity follows surgical trauma. Their effects may be moderated by the administration of Karo. It enriches the glycogen reserves thereby helping to prevent surgical acidosis, decrease post-anesthetic vomiting, stimulate the strained heart and combat shock.

After operation nutrition wanes when the patient cannot tolerate food. Karo with fluids helps maintain the water balance of the body and tides the patient over with basal energy. Karo provides 60 calories per tablespoon. It is relished added to milk, fruit juices and vegetable waters. Karo is a mixture of dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor), well tolerated, not readily fermentable, and effectively utilized.

Corn Products Consulting Service for Physicians is available for further clinical information regarding Karo. Please Address: Corn Products Sales Company, Dept. H-9, 17 Battery Place, New York City.

cial worker may continue to reenforce and supplement the work of the dietitian.

Problems that require careful social diagnosis and treatment before the dietetic department can accomplish successful results have been analyzed as follows by a medical-social worker:

1. Economic insufficiency due to inadequate income for the size of the family, poorly spent income, unemployment, dependency, and physical handicap for industrial life.
2. Broken homes.
3. Problems arising from alcoholism or drug addiction.
4. Social problems associated with mental disability.
5. Superstition, fear and ignorance.
6. Racial customs or religious beliefs.
7. Problems relating to environment (school situations, industrial conditions, standard of living).
8. Foster home problems.
9. Lack of family or home.

The recognition and social treatment of these problems by the social worker is particularly important to the work of the dietitian in a special clinic group.

I recall at the moment the case of a diabetic young woman who could not be kept sugarfree when outside of a hospital because of her repeated eating of sweets. She was referred for study to a social worker with psychiatric training who found that this patient had had a childhood in which she was greatly deprived of affection and in which other factors combined to give her so great a need to be indulged that she constantly had to pilfer sweets for herself. Without adequate social diagnosis and treatment for this patient, the dietitian was working against too great a handicap to achieve much success, no matter how skillfully and faithfully she worked.

As the dietitian attempts to have the meals of the diabetic as much like a normal diet as possible, so can the social worker try to have the patient and his family regard the patient as an ordinary member of the group. She must attempt to build up an acceptance of the disease by the patient and his group and an acceptance of an altered diet as a necessary and inescapable part of the treatment. If the family can be helped to be matter-of-fact about the illness and not consider the patient an invalid, while yet realizing the importance of the diabetic régime, the battle is at least well started toward victory.

With the ulcer patient, where nervousness, worry and fear so greatly affect the progress of the treatment, it is equally important that the personality of the patient and his associates be studied. In her earliest contact with the patient the dietitian should have the benefit of the social worker's study of him in order that she can start with this knowledge to give her the best possible rapport. As the treatment progresses, the dietitian will need to be kept informed of social problems and emotional disturbances in the patient's life so that she may help the patient to adapt his diet to the amount of emotional stress which he is under.

For the patient receiving relief, both dietitian and social worker can perform a real service by interpreting the budget so as to show its positive rather than its negative values. Probably any kind of a diet means, in the mind of the relief client, an extra allowance of money. When he is told that this is not true in the case of his particular diet, he may feel thwarted unless both dietitian and social worker stress that he can do many things with the money allowed, taking a positive attitude toward the situation.

Stimulating the pride of one mother in her skill in marketing, compensating for less intelligence by arousing the conscientious adherence to set rules in another—whatever means is best suited to the individual may be determined and utilized by both members of the team.

The more the social worker puts into this team play, the greater a return on her investment can she expect. The dietitian can be of infinite help to her in reenforcing the attitude toward his illness which she is attempting to implant in the patient by warning her of trouble signs which have been noted, by observing and reporting progress clues and by adapting the diet, within the limits of safety, to the emotional needs of the patient at a particular time.[1]

[1]Read at the meeting of the Tri-State Assembly, Chicago, May 6 to 8, 1936.

Saving Thirty Seconds to the Minute

By Iris Buus

Dietitian, Fairmont Hospital, San Leandro, Calif.

With the organization of a special diet laboratory at Fairmont the time of writing and preparing diets has been reduced fully 50 per cent.

ALTHOUGH the food is served from the ward kitchens at Fairmont Hospital, a large hospital having central service might easily use the same methods which we have found to be time saving.

Special diets are served to approximately fifty people, one-half of these being weighed diets for the diabetics. One dietitian may easily write the week's diets and work sheets during two days' time.

Before the dietitian calculates the basic outline, she visits each patient. At this time the purpose of the diet is explained and good eating habits are encouraged by careful phrasing of questions. It is wise to say, "I suppose you drink milk and eat most fruits and vegetables." Such questions as "What foods do you dislike?" or "Are there some foods which you dislike?" are not psychologically sound. They make it almost obligatory for the patient to think of some food which he will not eat.

Regardless of the amount of carbohydrate, protein and fat ordered by the doctor, it is both possible and practical so to calculate the individual's basic outline that it includes approximately either forty-four or sixty-four grams of carbohydrate to be obtained from fruits and vegetables. The remainder of the carbohydrate may then be provided by the use of all or some of the following foods—milk, cream, cereal, bread and crackers. The amounts of these foods plus the portions of bacon, eggs, butter and salad dressing may be recorded in the diet laboratory or in the ward kitchens and need not be written on the daily menu slips.

Since all portions of fruits and vegetables equal one hundred grams, these figures are not written on the patient's menu. Equal sized servings of fruits and vegetables make weighing simpler and eliminate the need of marking each order.

In general our procedure is as follows: Upon one sheet of paper are listed all diabetic patients. In addition to the name, this chart shows the patient's dislikes (if any), the amount of meat and the amount of bread at each meal. Bread is recorded to allow for substitutions when desired.

The menu for the day is essentially the same for all diabetic patients, with the exception that one group

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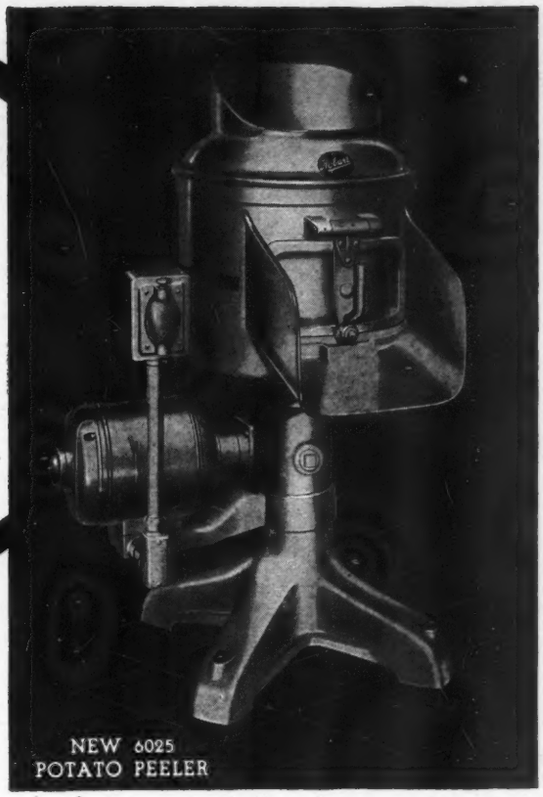
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Name.....

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receives twenty grams more carbohydrate than the other from vegetables, usually potato. For this reason one may make as many copies of each day's menu as there are patients to be served. By using carbon paper four or more menus may be written at one time.

When the menu for each day of the week has been written in this manner, the name, ward number and the amount of meat for the individual may be filled in. This process is continued for each patient taking account at this time of the idiosyncracies and special needs of each person.

All meat servings at night are either 100 or 50-gram portions. Meat substitutes such as cheese soufflé, stuffed eggs, oyster stew, stuffed peppers, cottage cheese, and other dishes may therefore be made in equal sized servings. All variations in the amount of meat are recorded for the noon meal.

The work sheet for diabetic diets is now little more than the day's menu with the number of portions of food equivalent to the number of patients. Formerly this sheet was a complicated mosaic of figures, each of which had to be cut out and deposited upon the correct food.

As is customary in most hospitals, unweighed special diets are written as much like the general hospital menu as possible. Extra fruits and vegetables, as well as some of the meat substitutes, can usually be chosen from the diabetic menu.

Each of these patients is listed with notation as to dislikes and diagnosis, and a suitable menu is outlined. When several people are writing diets in the course of a month this outline is helpful. It lessens the likelihood of too great variation in interpreting what constitutes a suitable menu for each person. These diets are written separately with the exception that the patient's name, ward and routine orders are put on the menu slip with the aid of carbon paper.

In our hospital two student nurses prepare the food for the special diets. Formerly four to six nurses were required to do this.

The purpose of any method of writing and preparing special diets is to serve the patient effectively. If this may be accomplished as satisfactorily by spending 50 per cent less time doing the routine processes we may then find it possible to give more time to the changing needs of the patient and to the continuous development of the department.

Canned Goods — When and How Much to Buy

In these times of rising food prices, the question as to whether or not it is advisable to lay in supplies of canned foods is constantly being brought up. An outstanding authority on canned goods has made a few comments on the situation which should be helpful. The following are his statements:

During July a dramatic change took place in the canned foods trade, a change from a buyer's market to a seller's market — a change from a condition where the manufacturers and distributors were pressing their merchandise for sale to one where the users were seeking supplies.

The source of this condition is the widespread drouth, lasting from early July to the middle of August, but the immediate causes were:

1. The average consumer had more money to spend than formerly, and more desire to buy.

2. On account of low prices and a heavy sale of canned foods, canners' stocks had been well reduced, while distributors bent unusual efforts to go into the new season with clean floors, with the result that the general July 1 inventory was the smallest on record.

3. In the interim between the Ethiopian collapse to Mussolini's invasion and the Spanish revolution, the newspaper headline writers had only the drouth for the front pages, consequently the public was aroused to the condition which until then was known only to those vitally interested.

A mass buying movement began, and still persists, which brought to dealers sales breaking all records for this season of the year and advancing prices, first on scarce items and then on those not scarce. The increase in prices ranged from 10 to 100 per cent.

The drouth is a reality, but is limited. Corn is very short; beans, carrots, and beets are temporarily short, but good weather the next two months can partially remedy this. Cabbage is extremely short, but a late fall will make a vast difference in the supply. Tomatoes are late, but favorable weather during September and early October can ensure a large production. Apples and red sour cherries are only half a crop, due to the severe freeze last winter, and berries in the East that matured during the burning heat of July and early August are almost a total failure. However, the fruit and vegetable crops of the Pacific coast are bountiful.

After the present buying movement subsides, there will no doubt be some reactions in price, especially on those articles which are not in reality scarce. However, it is logical to believe that in the end it will be found that a general price level has been established on all lines which will be substantially higher than that which existed prior to July 1, possibly on the average by 20 per cent.

FOOD FOR THOUGHT

• A valuable outline for the education of public health nurses in nutrition was recently received. It was prepared by Anna DePlanter Bowes, director of nutrition education of the Philadelphia Child Health Society and appeared in *Public Health Nursing* in December. Mrs. Bowes has reprints of this article and no doubt would be glad to send copies to those interested in teaching public health nurses.

• Gertrude Brown of St. Luke's Hospital, Richmond, tells as follows of her method of handling guest trays:

"Selective menus are sent to the floors daily for use of all patients having graduate nurses. Patients' guests are required to order their trays from the selective menus, which must be sent to the diet kitchen at least one-half hour before serving time begins. Charges are $0.50 for breakfast and $0.75 for dinner and supper. Trays may be charged on patients' bills or paid for in the business office, as designated at the time a request is made. All requests are sent to the dietitian's office so that charges may be properly made and credit for income checked against per capita costs."

• A survey of all institutions classified as hospitals in the State of New York will appear in summary in this department sometime in the near future, but it is interesting to note the following classifications of the hospitals and their average food costs:

	Per Patient per Day
General	$0.42
Tuberculosis	.51
Children's	.27
Maternity	.54
Mental	.28
Convalescent	.33
Incurables	.36
Prison	.20
Contagious	.36
Eye, ear and throat	.37

• A report has just appeared in *Scientific Literature* of work on the complete analysis of hemoglobin, which gives a clue to the use of oxygen in the body. Considerably more work must be done before definite reports can be made, but it is expected that this research will give scientists a better understanding of the nature of the union of hemoglobin and oxygen and of the energy changes involved.

• An interesting booklet has just come from Norway, "Health and Nutrition," which gives the nutritive value of Norwegian canned foods as compared with common foods used in this country. The booklet not only contains information on nutrition but has some rather unusual charts for making this comparison.

VITAMINS IN CANNED FOODS

III. VITAMIN A

• The most characteristic evidence of severe human vitamin A deficiency, and one which is increasingly rare in this country, is xerophthalmia. Night-blindness, one of the manifestations that usually precedes xerophthalmia, has been recognized as a deficiency disease since the time of Hippocrates who described the disease, and its cure by eating liver. Infrequent reports of this disorder, however, still appear in the American literature. Most if not all of the symptoms accompanying a deficiency of vitamin A are thought to be the result of an impairment of the epithelial tissue (1). In this connection, a new method for the quantitative determination of this vitamin is based on the keratinization of germinal epithelia (2).

That vitamin A exerts an influence on the growth of human infants and children is also generally accepted.

As early as 1919, a relationship between vitamin A in plant foods and plant pigments was postulated. Research since that date has indicated that beta-carotene and some related compounds may be considered as provitamin A (3).

The vitamin A potency of fruits and vegetables is apparently due to their carotene content, since vitamin A as such has never been found in plant tissue. Ingested carotene is believed to be converted into vitamin A by enzyme action in the liver of the animal (4), in which organ the vitamin is stored.

Vitamin A in the form of carotene may be present in yellow, green or red pigmented fruits and vegetables—in the two latter cases, the yellow color of carotene being masked by other pigments present. Color alone, therefore, is not always a reliable index of potential vitamin A potency.

Both vitamin A and carotene are relatively stable to heat but are subject to destruction by oxidation. However, foods of both animal and plant origin, when canned by modern methods, have been found to retain their vitamin A potencies in high degree (5).

In fact, in some instances, practically no loss of vitamin A potency can be detected by formal bio-assays (6).

Commercially canned foods, therefore, may be used with the knowledge that they will contribute to the American dietary amounts of vitamin A entirely consistent with those contained in the raw materials from which they were prepared.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1927. J. Exp. Med., *46*, 699
(2) 1935. J. Nutrition, *9*, 735
(3) 1929. Biochem. J., 23, 803
(4) 1931. J. Biol. Chem., *94*, 185
(5) a. 1933. J. Am. Diet. Assoc., *9*, 295
b. 1931. J. Nutrition, *4*, 267
c. 1935. Am. J. Pub. Health, *25*, 1340
(6) a. 1925. Ind. Eng. Chem., *17*, 69
b. 1926. Ind. Eng. Chem., *18*, 85

This is the sixteenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

October Breakfast and Supper Menus*

By Mary McKittrick
Director of Dietetics, Mercy Hospital, Chicago

	BREAKFAST	SUPPER			
Day Fruit	Main Dish	Main Dish	Potatoes	Vegetable or Salad	Dessert
1. Oranges	Bacon	Lamb Stew With Vegetables		Lettuce With Sliced Tomato, Boiled Dressing	Applesauce and Ice Box Cookies
2. Grapefruit	Soft Cooked Eggs With Bacon	Hamburger With Rolls, Pickle Dressing		Molded Vegetable Gelatin Salad, Mayonnaise	Red Cherries, Spice Cake With Maple Icing
3. Stewed Figs	Link Sausage	Cold Meat	Baked Potatoes	Combination Vegetable Salad	Fresh Plums and Cookies
4. Honeydew Melon	Scrambled Eggs	Deviled Eggs, Cottage Cheese	Potato Puff	Buttered Green Asparagus	Fresh Pears and Fudge Cake
5. Bananas	Bacon	Corned Beef Hash With Poached Egg, Tartare Sauce		Lettuce, French Dressing	Red Raspberries and Coconut Cake
6. Grapefruit	Sausage Patties	Assorted Cold Meats—Sausage, Beef Rib, Leg of Lamb	Potato Chips		Grapes and White Layer Cake
7. Stewed Prunes	Bacon	Small Steaks	Small Browned Potatoes	Sliced Cucumbers, French Dressing	Canned Apricots and White Cup Cakes
8. Honeydew Melon	Soft Boiled Eggs	Veal à la King	Baked Potatoes	Perfection Salad	Peaches and Cookies
9. Bananas	Bacon	*Baked Tomatoes Stuffed With Chicken, Mushroom Sauce	Potato Puff		Fruit Salad and White Layer Cake
10. Stewed Figs	Scrambled Eggs	Sausage With Pineapple Rings	Glazed Sweet Potatoes	Kidney Bean Salad	Pears and Cookies
11. Oranges	Griddle Cakes With Maple Syrup	Escalloped Tuna Fish	Potato Chips	Combination Vegetable Salad	Royal American Cherries and Fudge Cake
12. Stewed Prunes	Scrambled Eggs With Bacon Ends	Salt Pork With Cream Gravy	Baked Potatoes	Lettuce With Cucumbers, French Dressing	Apricots and Gold Cup Cakes
13. Grapefruit	Sausage	Assorted Cold Meats — Sausage, Lamb, Beef	Potato Salad		Sliced Pineapple and Coconut Cake
14. Applesauce	Bacon	Creamed Chipped Beef on Toast		Buttered Asparagus	Red Raspberries, Spiced Cake With Maple Icing
15. Bananas	Soft Cooked Eggs	Chicken Pot Pie	Baked Sweet Potatoes	Lettuce With Mint Gelatin, Mayonnaise	Peaches and Cookies
16. Grapefruit	Broiled Bacon	Sausage and Corn Fritters With Syrup		Stuffed Tomato Salad	Baked Apples and Gingerbread
17. Pineapple Juice	Broiled Ham	Escalloped Potatoes With Ham		Stuffed Pepper Salad	Apricots and Sweet Rolls
18. Oranges	French Toast With Maple Syrup	Creamed Eggs on Toast	Baked Potatoes	Asparagus Salad	Coconut Layer Cake
19. Tomato Juice	Bacon	Corned Beef Hash, Tartare Sauce		Molded Gelatin Salad, Boiled Dressing	Upside-Down Cake With Whipped Cream
20. Grapefruit	Sausage Links	Cold Meats	Escalloped Potatoes		Egg Plums and Cup Cakes
21. Prunes	Bacon	Lamb Stew		Stuffed Tomato Salad	Fruit Cup and Date Roll
22. Stewed Figs	Bacon	Ham and Eggs	Fried Potatoes	Stuffed Pear Salad	Pineapple and Sugar Cookies
23. Grapefruit	Soft Cooked Eggs	Creamed Chicken on Toast	French Fried Potatoes		Fruit Salad and Sweet Rolls
24. Stewed Apricots	Sausage Patties	Lamb Stew		Mint Gelatin Salad	Peaches and Marble Cake
25. Oranges	Griddle Cakes With Honey or Maple Syrup	Baked Macaroni and Cheese		Vegetable Salad	Pears and Cup Cakes
26. Pineapple Juice	Bacon	Hot Roast Beef Sandwich	French Fried Potatoes	Combination Salad	Apricot Upside-Down Cake
27. Baked Apples	Link Sausage	Cold Meats	Potato Scallops		Grapes and White Layer Cake
28. Tomato Juice	Bacon	Lamb Chops With Mint	Browned Potatoes	Stuffed Celery	Plums and Cookies
29. Prunes	Broiled Ham	Creamed Chipped Beef on Toast	Baked Potatoes	Combination Vegetable Salad	Peaches and Cookies
30. Grapefruit	Bacon	Baked Beans		Sliced Tomatoes	Fruit Cup and Fudge Cake
31. Stewed Apricots	Sausage Patties	Chicken Pot Pie	Glazed Sweet Potatoes	Corn Relish	Fruit Salad and Almond Coffee Cake

*Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, CHICAGO.

NEWS IN REVIEW . . . .

Protestant Church Hospitals to Hold Own Meeting Preceding A. H. A. Convention

Finance, the socialized care of the sick, and the trend of the nursing school, problems peculiar to church hospitals only in their interpretation, will be the high light talks of the day and a half meeting of the American Protestant Hospital Association, September 26 and 28. Dr. Charles S. Woods, superintendent, St. Luke's Hospital, Cleveland, will welcome the association to that city at its opening session over which E. E. King, president of the association and superintendent, Missouri Baptist Hospital, St. Louis, will preside.

A. M. Calvin, executive manager, Midway and Mounds Park Hospitals, St. Paul, Minn., will speak on the purposes of the organization. This will be followed with a discussion of his talk by Lake Johnson, superintendent, Good Samaritan Hospital, Lexington, Ky. The final talk of the session will be Dr. Fred G. Carter's discussion of the financing of church hospitals. Doctor Carter is superintendent of Christ Hospital, Cincinnati.

A round table conducted by Dr. Malcolm T. MacEachern, American College of Surgeons, will open the afternoon session. Clinton F. Smith, superintendent of Grant Hospital, Chicago, will give the first talk, "The Church Hospital and the Trend to Socialize the Care of the Sick." The Rev. Paul R. Zwilling, assistant superintendent, Evangelical Deaconess Home and Hospital, St. Louis, and Paul H. Fesler, superintendent, Wesley Memorial Hospital, Chicago, will discuss Mr. Smith's talk.

"What are we going to do with our nursing schools?" is the question to be asked by Dr. Claude W. Munger, president elect of the American Hospital Association. Joseph G. Norby, superintendent, Fairview Hospital, Minneapolis, Edgar Blake, Jr., superintendent of Methodist Episcopal Hospital, Gary, Ind., and Mary Roberts, editor, *American Journal of Nursing*, will attempt to help him answer it in the discussion to follow.

The President's Night program will consist of talks given by the Rev. Frank C. English, advisory secretary, American Protestant Hospital Association; Dr. Charles S. Woods; the Rev. N. E. Davis, director, Homes and Hospitals of the Methodist Episcopal Church; Robert Jolly, superintendent, Memorial Hospital, Houston, Tex.; the Rev. Herman L. Fritschel, superintendent, Milwaukee Hospital (Passavant), Milwaukee; the Rev. J. H. Bauernfeind, director, Evangelical Hospital, Chicago; Dr. B. A. Wilkes, Hollywood, Calif.; A. O. Fonkalsrud, superintendent, Mansfield General Hospital, Mansfield, Ohio; the Rev. Thomas A. Hyde, superintendent, Christ Hospital, Jersey City, N. J.; Charles S. Pitcher, hospital consultant, Philadelphia; the Rev. Charles G. Jarrell, secretary, general hospital board, Methodist Episcopal Church, South, and Mr. King.

On Sunday, when no meetings will be in session, members of the association will speak in the various Protestant churches of Cleveland. The business session is scheduled for Monday morning, opening with a breakfast meeting. Mr. King will preside at this session when the executive secretary, treasurer, and committees will give their reports and officers will be elected and installed.

England's Contributory Schemes Show Growth

Hospital contributory schemes in England had an excellent growth during 1935 if the experience of the Merseyside Hospitals Council may be considered as representative. This council, started in 1927, had a total of 309,267 contributors at the end of 1935 according to the annual report just published. These people contributed a total of £125,961 (approximately $630,000) toward their support when hospitalized. In addition most of the employers added the "employer's third" which increased the contributions by another £26,675 (approximately $133,000).

While these contributions plus other income of approximately £13,000 gave the council approximately $750,000 to distribute to the twenty-one voluntary hospitals associated with the council, the income from contributors averaged only 1¾d a week. In the opinion of Lord Cozens-Hardy, chairman of the council, this amount is "inadequate and not commensurate with the valuable and costly services received in return." Those who contribute through their places of employment bring down the average since the "unattached" contributors pay 1d for each £ of income or fraction of a £ with a minimum contribution of 2d per week. The chairman recommends that this same rate be established for all.

The Merseyside Hospitals Council has taken a lead in promoting mutual agreements between hospital contributory schemes throughout the country and, according to the report, there are few important hospitals in the country in which the Merseyside letter of introduction is not accepted and free service given to Merseyside contributors, this service being paid for by the council. On the other hand certain other contributory plans are not meeting the costs of serving their patients who come to Liverpool. Service to contributors to other funds cost the associated hospitals a total of $150,000 during 1935 and they were able to recover only $70,000 from these funds.

The auxiliary services of the council continued to grow in size. In 1935 there were 2,045 contributors and dependents given convalescent care, 20,389 journeys of ambulances to carry contributors to in-patient or out-patient services and 419 calls on the volunteer motorists who bring relatives and friends to patients in critical condition.

Nurses' Salaries Raised

Nurses at the Cook County Hospital, Chicago, are to have their pay raised fifteen dollars a month. This increase brings their monthly salaries to $65 with room and board, and, it is hoped, will prevent a wholesale resignation by the nursing staff. At the same time the finance committee authorized an additional appropriation of $30,000 for free medical care for persons not on relief. The yearly appropriation of $70,000 for this purpose has been almost exhausted.

Affiliates With University

The nursing school of St. Francis Hospital, Evanston, Ill., has established affiliations with Loyola University, Chicago, with the university's authority covering educational policy and administration. At the present time the school is accredited by the Illinois state board of registration and education, but under the jurisdiction of Loyola student nurses will have increased opportunities for academic studies. Two courses will be offered, the three-year course, which will entitle the student to the university's certificate of graduate nurse, and a five-year course for students who enter the training school without college preparation.

Hospital Standardization Conference to Emphasize Records and Obstetric Care

Theater technique will be introduced into the program of the nineteenth annual Hospital Standardization Conference, to be conducted by the American College of Surgeons in Philadelphia, October 19 to 23. Dramatization will be used to emphasize the importance of medical records, their compilation and use, by the Medical Record Librarians of Philadelphia, while in a less theatrical sense it will be employed by the staff of the Pennsylvania Hospital in its demonstration of maternal care, obstetric technique and procedures.

These two important problems are to be thoroughly covered by the conference which is devoting Monday afternoon, under the direction of Dr. George W. Kosmak, editor, *American Journal of Obstetrics and Gynecology*, to the care of the obstetric patient in the general hospital, and Tuesday afternoon to a demonstration of this care. All of Wednesday will be turned over to a meeting with the Record Librarians of North America, at which Dr. R. C. Buerki, president of the American Hospital Association, will preside.

1936 Survey to Be Given

The opening session of the conference will be held on Monday morning, with Dr. Donald C. Balfour, president of the American College of Surgeons, presiding and giving the opening address. The 1936 survey of hospital standardization will be given at this time by Dr. George Crile, director, Cleveland Clinic Foundation, who will be followed by Dr. Bert W. Caldwell, executive secretary of the American Hospital Association, discussing medical science, hospital service and the patient.

The surgeon's interest in hospital organization, management, and its many problems will be outlined by Dr. Frank N. Adair, executive officer, Memorial Hospital, New York City. Dr. Ray K. Daily, ophthalmologist at Jefferson-Davis, Memorial and Methodist Hospitals, Houston, Tex., will talk on staff conferences as the keystone of scientific efficiency of the hospital.

Dr. Charles C. Norris, director of the department of obstetrics and gynecology, University of Pennsylvania, and Dr. Carl Bachman, assistant professor, will discuss the adequate care of the obstetric patient in the general hospital from the standpoint of the specialized practice of obstetrics, on Monday afternoon. This subject will be analyzed from the viewpoint of the general practice of medicine by Dr. Walter Brand, director of obstetrics and gynecology at the Women's and Children's Hospital, Toledo, Ohio; from that of anesthesia and analgesia by Dr. Edward L. Cornell, Chicago Lying-In Hospital and Dispensary; from that of nursing care by Clara M. Konrad, assistant superintendent and directress of nurses, Margaret Hague Maternity Hospital, Jersey City, N. J., and from an administrative point of view by Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland.

Three additional talks will complete the day's program: "The Control of Morbidities and Mortalities," by Dr. John R. Fraser, professor of obstetrics and gynecology, McGill University; "Graduate Training for Obstetrics," by Dr. George W. Kosmak, and "The Work of the Committee on Maternal Welfare," by Dr. Fred L. Adair, professor of obstetrics and gynecology, University of Chicago.

General problems referring to hospitalization are to be taken up by the organization on Tuesday morning under the leadership of Dr. Claude W. Munger, president-elect of the American Hospital Association. Dr. William C. Tenery, chief surgeon, Waxahachie Sanitarium, Waxahachie, Tex., will discuss what the approved hospital means to the small community, and Dr. L. F. Anderson, attending anesthetist, Millard Fillmore, Emergency, and Lafayette General Hospitals, Buffalo, N. Y., will analyze the organization and management of an efficient anesthesia service in a hospital.

The medical fifth year is the subject of the talk to be given by Dr. Harold L. Foss, surgeon-in-chief, George F. Geisinger Memorial Hospital, Danville, Pa. Ruth M. Kahn, chief of the food clinic, Washington University Medical School, St. Louis, will speak on the need for dietary direction for surgical patients; Dr. William H. Walsh, hospital consultant, Chicago, will discuss air conditioning in hospitals, and Katherine Densford, director, school of nursing, University of Minnesota, will talk on the adequacy of nursing care of the patient.

Maternal Care

The demonstration of maternal care, obstetric technique and procedures, conducted by the staff of the Pennsylvania Hospital in the afternoon, will cover prenatal care, the admission of patients and their assignments to accommodations, the preparation of the patient for labor, observation of the patient in labor, delivery room set-up, obstetric technique and procedures, care of the patient immediately postpartum, care of patient throughout puerperium while in the hospital, follow up and end results, care of the newborn, and the handling of such emergencies in obstetrics as shock, postpartum, hemorrhage, convulsions and asphyxiation of the newborn.

The preservation of the voluntary hospital will be discussed by Newton E. Davis, Board of Hospitals, Homes and Deaconess Work of the Methodist Church, on Tuesday evening, when a general discussion will be conducted by Dr. Allan Craig, director, Charlotte Hungerford Hospital, Torrington, Conn. A motion picture on good hospital care will close the evening's program.

The opening talk at the medical record librarians' session with the conference on Wednesday will be the necessity for a high standard of diagnostic accuracy in all hospitals, by Dr. George Baehr, executive committee, National Conference on Nomenclature of Disease. The value of records and the proper classification of disease will be reviewed from the attitude of the urologist, the pathologist, the otolaryngologist, the cardiologist and the obstetrician. A demonstration — "Developing a Medical Record Consciousness Throughout the Hospital," will be conducted by Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, and editor of The MODERN HOSPITAL.

A round table panel, conducted by Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., Dr. R. C. Buerki, and Dr. Malcolm T. MacEachern, department of hospitals, American College of Surgeons, will close the conference on Thursday. Lasting all day, it will concentrate on the administrative, professional and economic problems relating to hospital service.

Sales Taxes Are Dropped

State sales taxes appear to be on the wane, according to a tabulation by the Council of State Governments. So far four of the twenty-eight states that enacted sales tax measures at one time or another have dropped them. Of twenty-one states that now have these taxes in force, eleven are operating under temporary laws which will expire in 1937.

The tax expired automatically in Maryland and Pennsylvania. In Kentucky and New Jersey it was repealed. The Oregon law never was on the statute books because it was defeated by referendum three times. Minnesota's law was vetoed.

Unless new laws are enacted the sales tax will expire next year in Arkansas, Colorado, Idaho, Iowa, Missouri, North Carolina, North Dakota, Ohio, Oklahoma, West Virginia and Wyoming.

A. C. H. A. to Study Training Needed by Administrators

The training of hospital administrators from their general preparation, through their education, to their practical experience will be the subject upon which the interest of the American College of Hospital Administrators will be focused at the organization's third annual convention in Cleveland, September 27 and 28.

At the convocation on Sunday evening, the college will grant twenty-six fellowships, fifty-five memberships and three honorary fellowships. These last will be given to Sydney Lamb, secretary, Merseyside Hospital Council, Liverpool, England; Capt. J. E. Stone, administrator, Birmingham Hospitals Centre, Birmingham, England, and Sister M. Olivia, dean of nursing education, Catholic University of America. Dr. B. W. Black, administrator, Alameda County Hospitals, Oakland, Calif., the speaker of the evening, will discuss "Hospital Career Men and Women."

Speakers at the general session on the training of administrators will be Father Alphonse M. Schwitalla, dean of the school of medicine, St. Louis University; Dr. Joseph C. Doane, editor, The MODERN HOSPITAL, and administrator, Jewish Hospital, Philadelphia; Michael M. Davis, director, medical service, Julius Rosenwald Fund, Chicago, and Dr. Claude W. Munger, superintendent, Grasslands Hospital, Valhalla, N. Y.

An attempt will be made at the business meeting on Sunday afternoon to revise the constitution and by-laws in order to broaden the scope of membership and to divide the United States and Canada into fifteen geographical sections for the purpose of unity. Dr. Basil C. MacLean, administrator, Strong Memorial Hospital, Rochester, N. Y., the incoming president, will deliver the presidential address.

Social Workers Meet in London for Conference

Social work and the community was the general subject of the third international conference of social workers held at Bedford College, London, England, in July. The theme was considered both generally and in relation to various types of work. Commissions on health, education and recreation, material welfare, social adjustment and unemployment were appointed by the conference to study in detail the relationship of these subjects to the conference theme.

The commission on health, reporting at the morning session of the last meeting, emphasized that social deficiency is often the cause of disease and that to remedy this health services should be made available in social and health centers. The aim was agreed to be a closer integration of the factors of health and welfare.

"Following the conference," writes Dorothy T. Pearse, member of the social service department of Cook County Hospital, Chicago, "a three-meeting session of medical social workers and lady almoners from Great Britain, France, Germany and the United States was held under the leadership of Dr. Richard Cabot. The doctor threw out for discussion questions dealing with errors in our practices."

93 Registered for Institute

The greatest distance record among hospital people attending the Institute for Hospital Administrators at the University of Chicago, September 2 to 23, will undoubtedly be held by Dr. Russell D. Bussdicker, of Kermanshab, Persia. The rest of the ninety-three who have registered at this time, however, are coming from Bermuda, Canada, Hawaii and thirty states. The university has arranged living quarters for those attending the Institute at Judson Court, a new group of residence halls.

Librarians to Meet With A. C. S.

The Association of Record Librarians of North America will hold their eighth annual conference at Philadelphia, in conjunction with the hospital conference of the American College of Surgeons, from October 19 to 23. The association has planned a series of addresses for Tuesday morning, following the Monday registration and tea, and, for Tuesday afternoon, a symposium on problems and achievements in conducting the medical records department. Wednesday will be given over to a joint meeting with the college. A symposium on nomenclatures — standard, alphabetical, and Massachusetts General—will be given on Thursday morning followed by a sight-seeing tour and a tea. The organization's business meeting will be held on Friday.

Minnesota Technologists Meet

The Duluth Society of Medical Technologists became the nucleus of a statewide organization of technologists when, at its July meeting, a temporary chairman for the state organization was chosen from among its membership. The Duluth group is the only local association in Minnesota with an entire enrollment of registered technologists. Sister M. Alcuin and Ruth Mingo, both of St. Mary's Hospital, were chosen president and secretary respectively, of the local organization.

Nurse Anesthetists Plan Varied Cleveland Program

The fourth annual meeting of the National Association of Nurse Anesthetists will be held at Cleveland on September 29, 30 and October 1, in conjunction with the American Hospital Association Convention. To vary its series of planned talks, the association has scheduled a tour of the city, including visits to two manufacturers of anesthetic gases, for Tuesday morning, and special clinics at the University Hospitals for Wednesday morning.

The ideal anesthetist will be described by Sister John Edward Kaiser, Good Samaritan Hospital, Dayton, Ohio, at the Tuesday afternoon session. This will be followed by a round table on endotracheal anesthesia under the leadership of Hattie Vickers, Vanderbilt University Hospital and Medical School, Nashville, Tenn., assisted by Caroline B. Hallberg, Northwestern Hospital, Minneapolis. The association will hold its general business session on Wednesday afternoon.

The actual uses of anesthetics are to be covered on Thursday, when Helen C. Kraus and Florence Schwab, Temple University Hospital, Philadelphia, will talk on cyclopropane; Howard T. Karsner, M.D., University Hospitals of Cleveland, on oxygen, and J. L. Reycraft, M.D., Cleveland, on anesthesia in obstetrics and gynecology. Explosion hazards in anesthesia will be discussed by Victor Phillips, consulting engineer to the University Hospitals, Cleveland.

Announce 1937 Meeting Date

The Hospital Association of Pennsylvania will hold its next annual meeting at Buck Hill Falls, Cresco, Pa., June 2 to 4, 1937, according to an announcement made by John N. Hatfield, executive secretary of the organization.

Coming Meetings

Institute for Hospital Administrators.
Next meeting, Chicago, Sept. 9-23.

American College of Hospital Administrators.
Next meeting, Cleveland, Sept. 26-28.

American Protestant Hospital Association.
Next meeting, Cleveland, Sept. 26-28.

American Hospital Association.
Next meeting, Cleveland, Sept. 28-Oct. 2.

National Association of Nurse Anesthetists.
Next meeting, Cleveland, Sept. 29-Oct. 1.

Children's Hospital Association.
Next meeting, Cleveland, Sept. 30-Oct. 1.

American Dietetic Association.
Next meeting, Boston, Oct. 11-16.

American College of Surgeons.
Next meeting, Philadelphia, Oct. 19-23.

Association of Record Librarians of North America.
Next meeting, Philadelphia, Oct. 19-23.

Ontario Hospital Association.
Next meeting, Toronto, Oct. 19-23.

American Public Health Association.
Next meeting, New Orleans, Oct. 20-23

NEW BUILDING PROJECTS

MOBILE, ALA.—Construction, repairs and alterations amounting to $100,000 have been announced by the United States Marine Hospital. These will include the demolition of the old laundry building and erection of a new one; reworking of the old portion of the hospital; tearing out and rebuilding the interior; repainting the entire building, and replacing the bathrooms in the old portion of the hospital.

LA VINA, CALIF. — The rebuilding program of La Vina Sanatorium, which was destroyed by fire last October, is scheduled for almost immediate action. Two buildings, one for adult patients and one for children, are provided in the plans drawn by Myron Hunt, Pasadena, Calif., architect. Together, these buildings will accommodate seventy persons, twenty of whom will be children. The program calls for an expenditure of $150,000.

ALTON, ILL. — A solarium built of glass bricks, believed to be the first of its kind, will be one of the claims to fame of St. Joseph's Hospital's new building which is now under construction. Many of the rooms in the new structure, which is being erected directly west of the present hospital building, will be air conditioned.

PEORIA, ILL.—A sixth floor addition of twelve rooms is under construction at the Methodist Hospital of Central Illinois at a cost of $20,000. It will house the x-ray department, permitting the present x-ray quarters to be turned into needed operating room space.

MINNEAPOLIS, MINN. — The Whitney Memorial Building, an addition now under construction at St. Barnabas Hospital, is to be fireproofed, air conditioned and acoustically treated throughout. Costing $150,000, it will be five stories high and have accommodations for 150 beds. According to present plans, it will be ready for occupancy by January, 1937.

ORANGE, N. J. — Students enrolled in the school of nursing at St. Mary's Hospital, will this fall attend classes in a new building, constructed for the purpose of housing the school. The $10,000 structure will contain a classroom, a laboratory, the supervisor's office, a demonstration room and an assembly hall. It will be connected with the nurses' home. Space in the hospital, formerly occupied by the training school, will be utilized to provide additional accommodations for patients and clinics.

ALBANY, N. Y. — The former city isolation hospital is about to be remodeled for use as a children's hospital under the auspices of St. Margaret's Home and Hospital. The plans call for the sum of $22,000 to be spent in relaying floors, redecorating walls and ceilings and renovating the heating system. The first floor of the building will be used for facilities for the children, including baths, playrooms, an operating room, doctors' offices, examining rooms, a formula room and a staff living room. Quarters for the supervising staff and nurses will be on the second floor, and the basement will house a nurses' dining room, a staff dining room, boiler room, kitchen and laundry, and quarters for employees.

NEW YORK CITY. — Plans have been completed and work will soon be started on the $1,000,000 Schervier Hospital for the Chronic Sick, being built by the Sisters of the Poor of St. Francis. The site chosen for the hospital is one of the highest in West Bronx and affords a view of the Hudson River. It will be seven stories, with accommodations for 416 patients. There will be 84 private rooms and 84 four-patient wards. Each floor will have two lounges, and on the seventh floor will be a solarium commanding a view of surrounding roof gardens. Operating rooms, x-ray, ophthalmology, dentistry and therapy rooms will be on the sixth floor. The kitchen and its allied departments will be in the north wing of the basement, with dining rooms for the personnel adjoining. The laundry will be in the south wing, and the central wing will contain an auditorium.

NEWPORT, R. I. — Construction was recently begun on a $125,000 addition to Newport Hospital, one story to be added to the top of the present Carey Ward, and three stories to be built adjoining it, facing on Friendship Street. The first floor will provide for a modern out-patient department, while the second and third floors will house the new maternity department, with the labor, delivery and waiting rooms on the second, and the nursery, service rooms, ward and private rooms on the third. The present Carey Ward building will be converted into storerooms and offices.

HOUSTON, TEX. — The cornerstone of the new plant under construction for the Jefferson Davis Hospital at a cost of $2,230,000 was laid recently. The three-unit structure consists of an eleven-story main building, with accommodations for 500 patients, a seven-story nurses' home with 151 beds and class and demonstration rooms, and a one-story power and laundry plant.

Brooklyn Cancer Institute Soon to Be Opened

September 15 is the date definitely set for the opening of the new Brooklyn Cancer Institute which will form an important unit of the Kings County Hospital Medical Center in that city. The institute is organized as an independent clinical unit of the Department of Hospitals, Division of Cancer, and includes an in-patient and out-patient service. For general administrative purposes the institute is under the supervision of Dr. Edward M. Bernecker, medical superintendent of Kings County Hospital. Beds are to be used, as far as possible, for cases of doubtful classification and for recognized tumor cases requiring short periods of hospitalization.

The physical plant, a five-story brick and stone building, houses both in-patient and out-patient departments, and has a bed capacity of eighty-five. The ground floor is given over largely to the dietary, admitting division and storeroom. On the first floor are the out-patient department, diagnostic and therapy departments. The second, third and fourth floors are devoted to in-patients, wards, with an operating suite (two rooms) on the fourth floor.

Pacific Hospital to Be Sold

Negotiations are under way for the purchase of Pacific Hospital, Eugene, Ore., by the Sisters of St. Joseph. This is one of the largest hospitals in the state, outside of Portland, and was opened in 1924 as the Pacific Christian Hospital, one of the hospitals of the Christian Church. In 1931, the hospital went into receivership, and continued in this status until 1933, when it was reorganized under the Pacific Hospital Society. The eighty-bed institution is valued at $250,000.

Manhattan General Moves

The Manhattan General Hospital, New York City, has moved from its old quarters to the former building of the Lying-In Hospital on Second Avenue. A twenty-one-year lease on the building was taken by the hospital. With two and a half times as much room as it formerly had, the hospital plans to devote 10 per cent of its daily bed service to semicharity cases and to develop a department of chest surgery.

Accept Ford Hospital Site

The thirty-seven-acre site at Dearborn, Mich., donated by Henry Ford for the new $1,500,000 veterans' hospital, has been accepted by the government. The hospital, when built, will have accommodations for 350 patients and space for the regional office of the administration.

NAMES IN THE NEWS • • •

DR. SEYMOUR R. LEE, superintendent of Ancker Hospital, St. Paul, Minn., died in his hospital on August 10, following an appendicitis operation. Doctor Lee came to Ancker Hospital as an intern in 1926, and remained as house surgeon and resident physician until 1929 when he was made assistant superintendent. In 1934 he left Ancker to become superintendent of Hastings State Asylum, Hastings, Minn., and a year later was put in charge of the Willmar State Asylum, Willmar, Minn. He was recalled to Ancker Hospital as superintendent to succeed Dr. Fred G. Carter. DR. THOMAS BROADIE, assistant superintendent at the hospital, has been made acting superintendent.

DR. ARTHUR H. PERKINS, assistant superintendent of the Waterbury Hospital, Waterbury, Conn., has been appointed medical director of the Norfolk General Hospital, Norfolk, Va.

DR. NEAL N. WOOD, director, Hillman Hospital, Birmingham, Ala., has resigned effective September 1 to accept a new post as director of Starling-Loving Hospital, Columbus, Ohio. Doctor Wood entered hospital administration as a medical officer in charge of a twelve-bed army hospital at Fort Apache, Ariz., over twenty years ago. In commenting on this experience recently he recalled that "among the interesting old papers at this tiny post hospital were some records bearing the name of a later famous army surgeon, Dr. Walter Reed."

NATHAN S. JONAS, founder of the Jewish Hospital, Brooklyn, N. Y., thirty-five years ago, has been elected president of that institution.

THELMA B. WARD has been appointed superintendent of Hillcrest Hospital, Springfield, Mass., to succeed JANE F. SMITH who retired at the close of her twenty-third year in that position.

DR. J. L. VALLANDINGHAM has been appointed superintendent of the Eastern State Hospital, Lexington, Ky., to succeed DR. EDWARD DAVENPORT who resigned last December. DR. A. BURGESS CARTER, assistant superintendent, has been acting superintendent during the interim.

DR. MARK L. FLEMING, general medical superintendent of the department of hospitals, New York City, will retire October 1. Doctor Fleming has been constantly associated with New York public hospital service since he was graduated from Cornell Medical School in 1901. He will remain in touch with the city's hospitals as an administrative consultant.

DR. RAYMOND R. CROWE, member of the staff of the Davidson County Tuberculosis Hospital, Nashville, Tenn., has been appointed superintendent to succeed the late DR. BLACKBURN G. TUCKER.

CHARLOTTE JANES GARRISON, formerly superintendent of Newton Memorial Hospital, Newton, N. J., has been appointed superintendent of the new Virginia Municipal Hospital, Virginia, Minn.

DR. LESLIE M. JONES has resigned as superintendent of Epworth Hospital, South Bend, Ind., to enter private practice in South Bend and Mishawaka. The superintendency will be temporarily filled by EVELYN MCGUINESS, superintendent of nurses.

SISTER M. BERNADETTE, assistant superintendent of St. John's Long Island City Hospital, Long Island City, N. Y., has been appointed superintendent of that institution, to succeed SISTER MARY HILDA, who in turn will become assistant superintendent, according to the canonical laws of the order.

MILTON S. POTTENGER, for many years business manager of the Pottenger Sanatorium, Monrovia, Calif., died recently. He resigned from his position at the hospital two years ago because of ill health.

JOHN M. SMITH, formerly superintendent at Hahnemann Hospital, Philadelphia, has been appointed superintendent of Reading Hospital, Reading, Pa., where he succeeds the late WILLIAM M. BREITINGER.

DR. JEWELL R. WILSON of the staff of the Western State Hospital, Western State Hospital, Tenn., has been elected superintendent of that institution to succeed DR. E. W. COCKE, who resigned recently.

MARTHA HEIL, superintendent of nurses at Henrotin Hospital, Chicago, since 1923, died of heart disease at Wakefield, Mich., where she had been staying with friends while on a leave of absence she had taken in June.

JOHN I. BICKELL has been appointed supervisor of Napa State Hospital, Imola, Calif., a position left vacant by the recent retirement of OWEN MURRAY. Mr. Bickell has been assistant supervisor of the hospital since 1918.

MARY JO O'DELL, superintendent of Stone Memorial Hospital, Carthage, Mo., for the last three years, resigned on August 15 to be married. She is to be succeeded at the hospital by ALMA SHANK, Southwestern Sanitarium, Wichita, Kan.

DR. JOHN F. SHAW, who resigned from the office of superintendent of Central Maine Sanatorium, Fairfield, Me., in 1932, has been appointed to that position again, to succeed DR. PAUL WAKEFIELD.

DR. FRED BRYCE JEWETT, superintendent of Reeves Sanatorium, Melrose Highlands, Mass., died at Melrose Hospital, Melrose, following an illness of several weeks duration. Doctor Jewett, before his appointment to Reeves, six years ago, had been superintendent of two state hospitals in Howard, R. I.

DR. NOLAN D. C. LEWIS has been appointed superintendent of the Psychiatric Institute and Hospital, New York City, to succeed DR. CLARENCE O. CHENEY.

LEROY E. SECHRIST has been appointed superintendent of Blossburg State Hospital, Blossburg, Pa., to succeed MRS. MARY P. WALLACE.

Chicago Nurses Raise $800

Nurses in the Chicago area raised $800 for the Florence Nightingale International Foundation, during the two weeks showing of "The White Angel" under their auspices in a loop theater. Mrs. Lucy Van Frank, director, First District Illinois State Nurses Association, Dagmar Anderson, secretary of the association and Estelle Weltman, American Red Cross, were the organizers behind the showing.

Medical Society Praises Group Hospital Service

The medical profession of the county of New York recently praised group hospitalization in an unmistakable fashion, when its official publication, the *New York Medical Week*, carried an editorial, "Anticipation Fulfilled" in the issue of July 25.

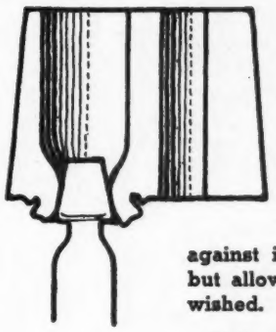
"The progress of the Associated Hospital Service is a source of satisfaction to its sponsors and advocates," the editorial said. "In its brief lifetime it has enjoyed a steady increase in subscribers without any sacrifice of promptness or efficiency in the distribution of benefits. A growing list of participating private institutions makes it possible for physicians without hospital appointments to treat patients under this plan. . . .

"The Medical Society of the County of New York was one of the earliest advocates of a group hospitalization plan. The success of the Associated Hospital Service to date is no less gratifying because it was expected."

"THE STOPPER THAT COULDN'T BE MADE"

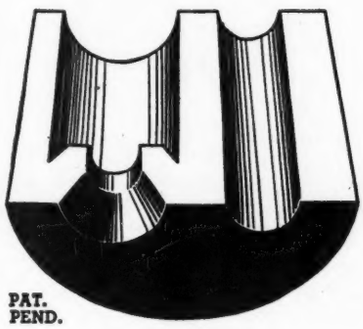
Cutter Laboratories Solve Difficult Problem

● In the past, hospital technicians have praised every feature of the Saftiflask...save one. They have liked the sturdy square base which prevented breakage and assured a positive grip on the bail...the accuracy with which contents delivered and contents remaining could be read at a glance...the ease with which the viscous seal and the cap were removed... and above all the assured safety of products adequately tested in a biological laboratory ideally equipped for such work.



To the left:
The ring of rubber evaginates, thus easily breaking the grip of dried dextrose.

However, they considered the connecting tube orifice an abomination, and rightly so. We can only admit that this objection was based on solid grounds; and you can't imagine with what a sigh of relief that past tense "was" is used.



PAT. PEND.

ABOVE
Cross-section of the new stopper showing live rubber ring that holds the tube.

After repeated trials a stopper was devised with a connecting tube-hole which fulfilled every wish. In a nutshell, the tube went in easily...came out easily...yet couldn't come out accidentally. It was so perfect we knew there must be a catch in it. There was. The diemakers and rubber moulders took one look at the sample and said, "It can't be done!"

CAN'T SLIP OUT
Tube withstands a 7-pound pull, but comes out easily with an 8-pound pull.

Being sublimely ignorant of the diemakers' and rubber moulders' arts, we insisted on being convinced. Inasmuch as it was our party at our expense they set out to show us. Somewhat to their chagrin and our great delight each Saftiflask now comes equipped with "the stopper that couldn't be made."

A glance at the illustration tells the story. The new connecting tube grip is simply a ring of live rubber which expands to let the tube in easily, whether wet or dry, and contracts to hold the constricted neck of the tube. An eight-pound pull is needed to remove the tube...sufficient to insure against its coming out accidentally, but allowing its easy removal when wished.

And even dried dextrose can't make it stick! Probably the greatest "bugbear" of previous stoppers was the fact that all too frequently the tube would be glued in with dried dextrose until even the Powerful Katinka couldn't remove it. But not now! We've even tried to glue the tube in this stopper with water-glass, and it can't be done. When an eight-pound pull is put on it, the ring of live rubber evaginates, breaking the seal, and out comes the tube!

SEND FOR IT TODAY

The new stopper and a regular connecting tube will be sent on request. Examine it and discover for yourself its advantages over old-type stoppers. Test it, and discover its almost unbelievable perfection!

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I've got to be shown! Let me see this "Perfect" Stopper.

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Hospital_____

Title_____

READER OPINION • • • •

Purchasing Groceries

Sirs:

In the August number I see a paragraph supplied by me entitled "Purchasing Groceries." Since the original was submitted our purchasing and dietary departments experimented with placing their grocery orders every two weeks. This was so successful that they have now cut it down to once a month, thus eliminating a great deal of calculation and reducing the number of orders and bills that have to be checked.

We do not, however, advise any hospital initiating such a system to begin on a monthly basis, as to do this successfully requires a good deal of experience and extensive knowledge . . . to enable you to prepare calculations of monthly quantities. . . . It is, however, evidence of the great possibilities of time-saving inherent in this method.

F. STANLEY HOWE,
Director.

Orange Memorial Hospital,
Orange, N. J.

FHA Machinery Loans

Sirs:

One regulation (of the FHA) is so easily misunderstood that I should like to call it to your attention. . . . It is in regard to machinery and equipment which do not become an integral part of the structure itself.

Insured loans obtained for the purpose of financing the purchase and installation of machinery and equipment must exceed $2,000 to be eligible. They may be part of larger loans, up to $50,000, but the amount borrowed for this specific purpose must exceed $2,000. There is no minimum restriction on loans for additions, alterations and repairs.

ROBERT B. SMITH,
Assistant to the Administrator.

Federal Housing Administration,
Washington, D. C.

"Costing" in the Small Hospital

Sirs:

In the July issue I read with a great deal of interest C. Rufus Rorem's article on "Cost Accounting in the Small Hospital." Of course, I may be wrong in what is considered a small hospital. Grand View Hospital is a 120-bed institution and we have an elaborate cost system. We feel that this system is responsible for the efficient management of the institution and feel that every hospital, regardless of size, should keep some sort of a cost account, the size, of course, depending upon the size of the institution and upon the amount of money available to keep up said accounts.

J. A. BLAHA,
Business Manager.

Grand View Hospital,
Ironwood, Mich.

Bids and Board Members

Sirs:

Several months ago I read with interest your editorial entitled, "Bids and Board Members." For some time I had been fighting this evil in the Montgomery Tuberculosis Sanatorium where I held the position as superintendent and medical director. Enclosed clippings will better serve to inform you as to how my services were regarded by the medical and lay public. Please return them.

Being a champion of honest hospital administration, I think that you would be interested to know that, when I presented to a committee of the board letters from the American Medical Association, American College of Surgeons, National Tuberculosis Association and American Sanatorium Association condemning business dealings with board members and your editorial mentioned above, together with letters from twenty-one medical superintendents all over the country, it resulted in a request for my resignation. This is explainable in a self-perpetuating board which gave business to board members without the formality of bids. I had, a year before, exposed the fact that the hospital was overinsured $8,000, and that one board member held more insurance than all the other local insurance agencies combined. Said board member is the treasurer and has the placing of the insurance besides being a business partner of the president.

Please be assured that my only interest in this is to correct an evil which I sought to correct while connected with the hospital. I have no interest in regaining any connection with the sanatorium.

I would be interested in any editorial comment that this information might stimulate, or any suggestions that you may have to work along lines for correction of this abuse.

Montgomery, Ala. B. W. COBBS, M.D.

The enclosed clippings include one in which the board of censors of the Montgomery County Medical Society praise Dr. Cobbs "for his excellent work" and for "conscientiously carrying out his duties." Another, a "letter to the editor" from Mrs. J. F. Duggar, Jr., of Hope Hull, Ala., calls attention to the fact that the sanatorium is a charitable institution and that "no board members should have any business connection with the institution for obvious reasons. . . . The Sanatorium is after all run for the patients and not for the board members. They are merely the administrators of a public trust and any item, whether it costs a small sum or a larger, should be contracted for from some one other than a board member. These points of business ethics were among the principles strongly advocated by Dr. Cobbs. On this point he differed from some of the board members. As citizens we feel grateful to him." Doctor Cobbs was also nominated by the local newspaper as one of "Montgomery's Useful Citizens." Dr. Thurston D. Rivers has been appointed to succeed Doctor Cobbs.—ED.

Subsidiaries and the League

Sirs:

At the time of the 1934 biennial convention the National League of Nursing Education had a committee on subsidiary workers in the nursing services . . . organized to study the whole matter of use, preparation and regulation of subsidiary workers in nursing services.

After studying the situation for some time the committee made the following recommendations to the League board at the January, 1935, meeting. The board accepted the recommendations:

1. It requests that the National League of Nursing Education support the principle that all persons who nurse for hire should be licensed.

2. It disapproves the opening of schools for the training of subsidiary workers until control of nursing practice is secured.

3. It believes that the term "nursing aid" is more desirable than "practical nurse."

Inasmuch as there was such difference of opinion among the profession regarding the use of, and the legislation regulating, subsidiary workers, the League board gave up its committee with the recommendation to the other two organizations—the A. N. A. and the N. O. P. H. N.—that a joint committee of the three organizations be appointed to study the matter further. It was believed by our board that some national opinion representing the thought of all three organizations should be secured for the guidance of the profession.

The other two national organizations approved the League's recommendations.

The whole matter is indeed a serious one and deserves all the attention that the three national organizations can give it. It would be quite tragic if the hospitals begin setting up courses for attendants at this time. . . .

Our organization is working rather closely with the division of nursing of the Council of the A. H. A., and I am hoping that the whole matter can be discussed with representatives of the A. H. A. and the A. N. A. There are many unemployed nurses at the present time who might be employed in hospitals if salaries and living conditions were better. . . .

CLARIBEL A. WHEELER,
Executive Secretary.

National League of Nursing Education,
New York City.

Misrepresentation Somewhere

Sirs:

Have you an authorized salesman in this territory?

One of our office staff reports that he was accosted by a young man in our lobby who offered to sell him a subscription to THE MODERN HOSPITAL for $2.50 per year, plus the annual YEARBOOK.

We cannot believe that any authorized representative of The Modern Hospital Publishing Company would visit an institution without seeking out the executive in charge and stating his business.

Please let us know if you have any knowledge of this person and his proposition. Inasmuch as we have been consistent subscribers of THE MODERN HOSPITAL for many years we would naturally believe that if there were any profits or lowered subscription rates we would secure the benefit of same, and not the persons casually subscribing through an agent. We believe there is misrepresentation somewhere and are advising you accordingly.

A. J. MACMASTER,
Superintendent.

Moncton Hospital,
Moncton, N. B.

The MODERN HOSPITAL does not have an authorized subscription salesman in New Brunswick or anywhere else. Salesmen are not employed, all subscriptions being secured through the mail. — Ed:

Institutional Dental Service Counted Routine Treatment

Most state hospitals and correctional and eleemosynary institutions under state control now provide dental service to the people in their care according to a recently published survey by the United States Public Health Service. In a total of 662 such institutions reporting, there were 480 who provide such service. Of these 172 institutions had full-time dentists and 307 had dentists on a part-time basis.

Institutional dental service in the report is defined as routine treatment, which includes examinations, odontexesis, tooth restorations (precious metals excepted), extractions and miscellaneous general treatment, furnished by registered dentists at institutions wholly or partially supported by state funds.

The report, which is published as Public Health Bulletin No. 227, contains summaries for each state of the dental activities of the state health department and of all state institutions. The survey was undertaken at the request of a committee of the American Dental Association.

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That is one reason why 53% of all the schools that use custom-made garments have their outfits made by Marvin-Neitzel. Of course these outfits must give a satisfactory account of themselves or these same schools would not come back to Marvin-Neitzel year after year. (We have outfitted some schools for more than twenty years.)

Now that the season for capes is here, you can find the cape you want from the wide selection Marvin-Neitzel offers. Write for the information you would like about capes or student outfits.

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Visit Booth 165 at the Cleveland Convention

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LITERATURE *in* ABSTRACT • • •

Conducted by E. M. Bluestone, M.D.

Souring Laundry Load

The purpose of a souring operation* is to neutralize residual alkali and to decompose any soap present in the load which has not been removed by the rinsing operation, leaving it in the form of the fatty acid of the soap stock. A load should never be soured until it has been rinsed sufficiently to secure adequate soap removal. Loaded net wheels require at least four, and under less favorable conditions five, hot rinses satisfactorily to remove excess soap and alkali. A reduced number of rinses should be used only when tests have indicated that proper rinsing is being obtained. Most of the sours now used in the laundry trade are compounds of fluorine. It is customary to add these sours to the wheel in the dry condition. A number of plants dissolve the sour and add it to the wheel in liquid form. This gives better distribution and no time is required for it to dissolve.

*Souring Methods, Starchroom Laundry J. 43: 58 (June) 1936. Abstracted by Joe R. Clemmons, M.D.

Three Group Plans From a Medical Standpoint

This report,* based on information obtained from the hospital service corporations in Cleveland, New York City and Washington, D. C., and from prominent physicians who have had experience with these plans, discusses characteristics common to all three which have given rise to doubts and questions on the part of the medical profession.

The first question relates to obstetrics. Cleveland makes no provision for obstetric service. New York provides a maternity service after a wait of ten months but will care for illnesses incidental to pregnancy before the full time if the attending physician certifies that the date of expectancy is beyond the ten-month period. In Washington it was suggested that obstetrics might be included after ten months by providing a 50 per cent discount to the subscriber. Under such an arrangement all illnesses incidental to pregnancy should be hospitalized. Physicians' obstetric fees are not included in any of the plans.

Problems have arisen in connection with laboratory and roentgen ray service and the administration of anesthetics. In Cleveland and New York anesthesia is included unless it is administered by the physician, in which case the bill is rendered directly to the patient by him. Washington does not include anesthesia in the benefits. New York and Cleveland include necessary technical roentgen ray service. However, the radiologist bills the patient directly for unnecessary radiograms.

In Washington no roentgen ray service of any kind is included. Blood, urine and simple routine tests are provided in New York and Cleveland, but in Washington the examinations are limited to blood, urine and Wassermann tests. The roentgen ray and laboratory difficulties arose because different practices had already existed in the way roentgen ray and laboratory services were supplied to patients. Some hospitals owned and operated their roentgen ray departments and procured the services of a radiologist on a salary basis. Others simply furnished the space and the radiologist owned the equipment and operated on a percentage basis. Still others were entirely independent. Almost all hospitals employ a pathologist on a full salary, as opportunities for the pathologist to derive income directly from paid work are meager.

The acceptance of insured patients under a group hospitalization plan does not alter any of the above conditions, but has precipitated a great deal of discussion. In one city, hospital pathologists were accused of contract practice and threatened with expulsion from the county medical society. However, when the case was referred to the American Medical Association the decision was in favor of the pathologists.

The logical solution of these problems seems to be to extend to subscribers exactly the same privileges now given other private room patients —no more and no less.

*Haythorn, Samuel R.: Group Hospitalization from the Medical Standpoint, Penn. M. Jr., 39: 409 (Mar.) 1936.

Washing Wool to Prevent Felting

Felting of wool* is due to movements of the fibers while wet. The prevention of felting reduces itself to the use of methods which will give good washing with a minimum of mechanical action on the wool. Various types of special washing machinery meet these requirements.

When wool is washed in wheels, the suds should be made up in the wheel and the bath carried at a high level before the wool is placed in it. The wheels should be stopped during the dumping and filling operation. Rinses of not more than two minutes at high water levels promote the best of rinsing. While underloading will increase the cost of supplies, it is more advantageous in that it decreases the washing time.

The temperatures of the various operations for wool should be held between 90° and 100° F. A good grade of neutral wool soap should be used. If an alkali is indicated, its use should be kept at a minimum.

*Felting of Wool. Starchroom Laundry J. 43: 58 (June) 1936. Abstracted by Joe R. Clemmons, M.D.

Improved Treatment of Fractures

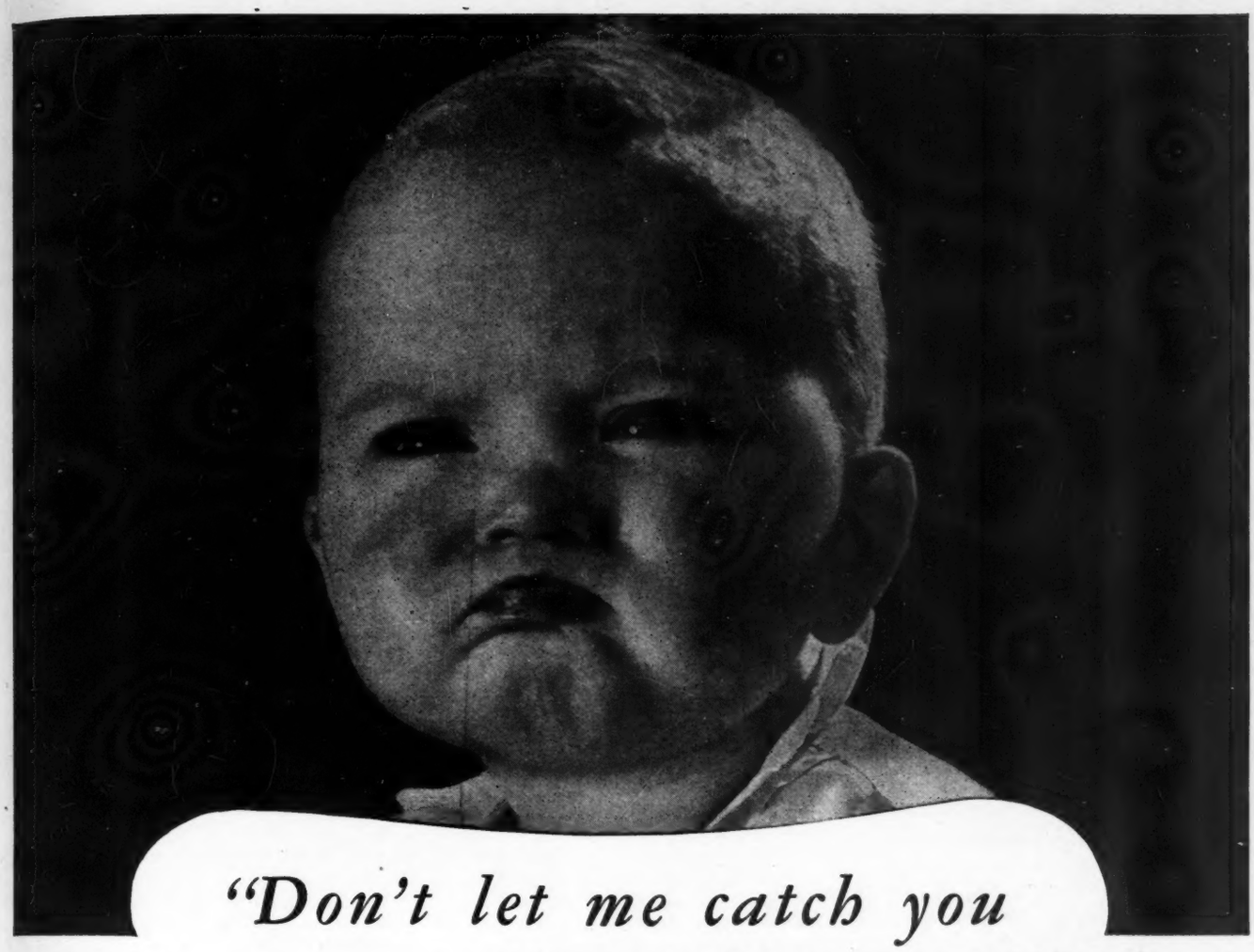
The American College of Surgeons has recognized the importance of the treatment of fractures as a branch of surgery. The organization of hospital fracture services has built up improved methods of treatment, records, follow-up for the bed patient. The author* outlines the organization of a fracture clinic for the treatment of ambulatory patients.

Ordinarily, the ambulant fracture patient is treated in the general surgical clinic by surgeons, some of whom may not be especially interested in fracture work. In order to raise the therapy of ambulatory fractures to a par with that of the hospitalized patient, the fracture clinic of the Beekman Street Hospital, New York City, was organized in July, 1933. The variety and scope of the work done may be seen in a three months' survey from January to March, 1934.

Four hundred and eighty-three patients with 823 fractures were treated. Two hundred and twenty-two patients (45.9 per cent) received 3,094 physical therapeutic treatments. Practically every bone in the body was represented. In view of the fact that as many as sixty patients were seen in one session a definite system of procedure had to be established.

The personnel includes the chief of the clinic with at least one month and, preferably, three months' continuous service, assistant surgeons, a female nurse, a male nurse, a stenographer and a filing clerk. All new cases are seen by the chief of clinic and all fractures seen in the out-patient department, except minor ones of the distal phalanges, are referred to the fracture clinic. The chief of clinic is also on ward service in the hospital for part of the year and is therefore familiar with the method of treatment of the hospitalized fracture patient.

The patients from the wards are referred to the clinic for follow-up. At discharge the patient is given a rating according to the Massachusetts Gen-



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As you perhaps know, most hospitals that are important in maternity work—in fact, more than 2200—now use Mennen Antiseptic Oil for softening and removing the vernix, for the baby's initial cleansing and for the daily oil bath.

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In antiseptic potency, Mennen Antiseptic Oil is equal to the commonly used ammoniated mercury ointments, yet it is absolutely non-irritant and non-toxic and can be used day in and day out without danger of dermatitis. It is pleasant to handle, leaves no greasy residue, does not discolor clothing or bed linen, and washes out easily.

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eral Hospital Plan and is seen again at a follow-up clinic. The value of such a fracture clinic lies in the fact that the patients receive more accurate treatment and there are fewer chances of error. The surgeons become familiar with ambulatory treatment of fractures, there is an opportunity for teaching, study and research and the patients appreciate the fact that something special is being done for them and give increased cooperation.

*Findlay, Robert T.: A Fracture Clinic. Bull. Am. Coll. Surg. 21:108, 1936. Abstracted by Arthur H. Aufses, M.D.

Solving the Pathology Laboratory Problem

The smaller hospital must offer an adequate laboratory service without providing all the special features of the laboratory of the larger hospital.*

The laboratory should have about 2,000 square feet of space for each 100 beds. Whenever possible, provision should be made for 2,500 to 3,000 square feet for the first 100 or 150 beds and 2,000 square feet for each additional 100. Upper floors are preferable to basements for laboratory work unless ample light can be provided.

The equipment should provide for the more common and less complicated examinations, including qualitative examinations of urine, blood, gastric contents and feces, as well as several of the less complex quantitative tests. The autopsy service necessitates a complete equipment of instruments, table and plumbing.

The personnel of the laboratory includes a director, house staff, technicians and, in some instances, a record clerk. In some of the smaller hospitals ward laboratory service is placed in the hands of technicians on the grounds that the work is better done in this way than when the house staff was required to make routine examinations. That is no longer true.

The number of technicians needed depends on the character of the hospital and volume of work required. Most important is the selection of a laboratory director. The problem of the smaller hospital is to obtain the services of a well trained, competent pathologist at a cost which is not prohibitive. Generally speaking it is probably uneconomical to provide a full-time director for a hospital of fewer than 250 or 300 beds. One person may serve several small hospitals satisfactorily if he is connected with one high grade, amply equipped and fully manned laboratory.

The institute of pathology, which is a part of Western Reserve University, Cleveland, and serves as a central laboratory for the university hospitals, has such an arrangement with several smaller institutions. The men who serve as part-time laboratory directors of smaller institutions have a well rounded training for three years in all varieties of laboratory work. The amount of time to be given by the pathologist is settled by the hospital authorities and the director of the institute. The salary paid is based on the amount of time required and the experience of the pathologist.

The time necessary for the work of the different hospitals varies. In one hospital three visits a week are required, in another the pathologist is present all of every morning, in two others he visits every week, and in still another he visits every two weeks. The arrangement as it concerns the personnel of the institute varies. In one case a senior assistant visits every week and has an assistant on the clinical staff of the hospital. Another senior assistant visits the hospital every two weeks and has no assistant other than a highly trained technician. An intermediate assistant makes short visits three times a week to two hospitals and once a week to a third. Another intermediate assistant is on duty at one hospital all of every morning.

By this arrangement the institute guarantees to provide a well trained and competent pathologist who has the backing, professional support and advice of the institute. The smaller hospitals do not have to pay a pathologist for full-time service. Special tests for which smaller institutions are not equipped may be performed at the institute.

*Karsner, Howard T.: The Laboratory of Pathology in the Small Hospital, J. A. M. A. 106: 1445 (Apr. 25) 1936.

Radiator Heating and Air Conditioning

Following a long period of disorganization,* the several groups most interested in promoting radiator heating have drawn together and organized. The result is the National Bureau of Heating and Air Conditioning with the manufacturing trade and installation interests making up its membership.

One of its purposes is to emphasize the importance of heating in any proposal to secure air conditioning. The initial pamphlet published by the bureau links up the phrases "radiator heating" and "air conditioning."

Radiator heating with a separate means of moving air or of heating, cooling or moistening it, has some technical advantages. Indeed there is a strong likelihood that some form of "split" system is likely to prove increasingly popular. The battle to see who is going to fall heir to the legacy of popular interest in the words "air conditioning" is by no means over. Let no one be misled into supposing that any one method or any one commercial group has yet succeeded to the title.

*Radiator Heat and Air Conditioning, Heat. & Ventil. 33:65 (May) 1936. Abstracted by Louise Large.

Hospital Dental Service

According to the American Hospital Association only 25 per cent of all hospitals throughout the United States having a bed capacity of 200 or more have a dental service.* Approximately 250 hospitals have a well defined dental service. Of the patients in wards, 95 per cent are in need of dental attention.

The mouth is one of the most important portals of infection in the human body. Of all cases at the Mayo Clinic, 61 per cent are the result of oral infection. Systemic disturbances are often discovered through oral diagnosis. Dental conditions in many cases have been the cause of systemic ailments and the physician should treat such patients in collaboration with the dental surgeon. Patients should receive adequate prophylactic dental treatment before taking a general anesthetic, thus building up their resistance. If dental foci of infection were eliminated, patients could be dismissed much earlier, and thus the hospital could care for more patients in each fiscal year. Rounds should be made with a dental intern in any good hospital.

There is urgent need of equipping surgical departments with facilities for exodontia and minor oral surgery. Closer association between the medical and dental staffs could be established if patients would be treated by the dental surgeon, in cooperation with the general surgeons, in small adjoining operating rooms. In order to have the needed preventive measures instituted and maintained, the dental profession must equip and support an adequate and efficient dental service with a sufficient number of dental interns as a standard required by the American Hospital Association.

The hospital that gives every patient a complete examination including the mouth, which carries out the treatment indicated and teaches its nurses the value of such a procedure, is an asset to public health because the patient is convinced that dental care should be continued and he spreads his belief to others. If a patient shows poor resistance and delay in recuperating and fractured bone fails to knit, irrespective of what the diagnosis has been a roentgenographic examination and a consultation with the dental department are imperative.

The dental roentgenographic department should not be separated from the medical. The two services would derive mutual benefit if the medical

staff could become acquainted with oral diagnosis by the study of negatives with the dental staff. J. L. Brown has pointed out the advisability of keeping dental and medical services in close contact, thereby according the dental service the recognition that other specialties enjoy.

The physician should not discharge a patient until all urgent dental treatment is completed for otherwise dental infection may lead to the latter's return to the hospital. If it is necessary to move a bedridden patient the attending physician should be consulted and the type of examination and treatment contemplated be discussed; thus the dental staff would be relieved of responsibility in the event of a fatality. At the same time the medical staff will realize that their valued opinion is not disregarded, but their guidance is solicited.

The advantages to a dental intern in his association with the hospital are that he becomes more tolerant and can follow a routine with little waste of time and effort in technical procedure. He has the incentive to make slides for himself as an aid to diagnosis. The hospital trained dentist treats the patients in his office with a greater sense of responsibility in regard to their physical needs and required medication than the average dentist.

*Morvay, Leonard S.: Relation of Dental to Medical Service, J. Am. Dent. A., June, 1936. Abstracted by David Tanchester, M.D.

Neurologic and Psychiatric Training

In this 102-page booklet* a problem is discussed which is assuming increasing importance in this age of medical specialization—the adequate training of the neurologist and the psychiatrist.

The physicians who take part in this symposium are outstanding leaders and teachers in their respective fields. Represented are neurologists of four nations—F. M. R. Walshe, London; B. Brouwer, Amsterdam; H. A. Riley, New York City, and J. Lhermitte, Paris; a pediatrician, B. S. Veeder, St. Louis; a "psychobiologist," Adolph Meyer, Baltimore; a psychiatrist, E. A. Strecker, Philadelphia; a neurosurgeon, W. Penfield, Montreal, and a "neuropsychiatrist," J. Ramsey Hunt, New York City.

The writers, almost without exception, agree on the importance of a thorough basic training in biology and medicine as a prerequisite for either specialty. Almost all of them feel that at least two and preferably three or more years of intensive postgraduate work in the field of choice are necessary before one can consider himself prepared for practice.

The chief difference of opinion between the neurologists and the psychiatrists is in whose domain the treatment of the psychoneuroses rests. The former claim that historically they have always been concerned with the investigation and treatment of disorders of the nervous system, both in its functional and in its organic aspects and that any attempt to separate the two is neither logical nor desirable. The latter claim that the majority of neurologists are inadequately prepared to treat the psychoneuroses and should therefore confine themselves to the organic diseases of the nervous system.

However, as the editors of the *Archives of Neurology and Psychiatry* point out in their excellent summation, there is no real controversy in principle. "The principle is one of thoroughness of neurologic and psychiatric training. Doctor Meyer speaks of the need for the 'psychiatrically intelligent neurologist.' To that one may add 'the neurologically intelligent psychiatrist,' with the great goal ahead of the medically and surgically intelligent 'neuropsychiatrist' who will be the physician to treat patients with nervous and mental disease."

*Training of the Neurologist and the Psychiatrist, published by the American Medical Association and reprinted from the Arch. Neurol. and Psychiat., 29 and 30, 1933, and 31 and 32, 1934. Abstracted by J. Marmor, M.D.

Malnutrition and the Depression

Until the depression the author felt that any nutritive failure in America was largely the result of ignorance and faddism. The investigation reported here* was undertaken in an effort to determine whether to the foregoing two factors had been added the influence of poverty.

Judging by (1) the weight and the increment of gain among school children as recorded before and during the depression, (2) the weights of the employed and unemployed among working men, together with estimates of fitness, (3) the testimony of welfare agencies and (4) the clinical observations of a selected group of physicians, the answer to the question is in the negative.

The author concludes that the nutritive state of the American school child has not suffered, nor has there been any widespread undernutrition. Although there are no doubt many exceptions, the vigor of the American working man is not recognizably inferior to that of earlier years. While the incidence of such deficiency diseases as pellagra and nutritional edema may have increased somewhat during the first years of the depression, it is markedly declining today.

It seems clear from these studies that relief agencies have done good work, the educational influence of their work adding greatly to its effectiveness. The insistent advice as to what to eat, and the resultant enlightenment in nutrition, even among the lowest economic classes, where formerly ignorance, added to poverty, caused malnutrition, are the outstanding findings of the investigation.

*McLester, J. S.: Influence of the Depression on the Nutrition of the American People, J. A. M. A. 106: 1865 (May 30) 1936. Abstracted by Elise Davis.

Cleansing Dirty Dishes Thoroughly

The function of dishwashing* is to clean and sterilize dishes, neither of which is possible when this work is done by hand. No human hand can stand the temperatures necessary to produce clean, sanitary dishes.

Ignorance has led managers to consider the reduction of inefficiency in the dishwashing department as an unnecessary evil, and they continue to hire a low grade of help. This investigation made it obvious that the subject of dishwashing needs careful analysis in 99 per cent of the hotels and restaurants in the country. The dishwashing department should receive the same intensive research that is now being given food preparation, accounting and merchandising.

A dishwashing machine will pay for itself in almost any institution by reducing breakage and total labor cost. It also greatly reduces the bacterial count on dishes. For instance, the count for one hand-washed article examined was 89,000, the count for the same article washed by machine was 3,700.

The first essential of economical dishwashing is a good layout, followed by good equipment and a highly trained personnel. The ideal plan is to have some one person who thoroughly understands the machine inspect it for an assurance of good service. Machines must be cleaned daily — inside and out — for clean dishes can never be produced from a dirty dishwashing machine.

Following are a few suggestions gained from the experiences of older departments. The use of rubber mats on the tables to prevent dishes from coming in contact with hard surfaces, wooden racks placed so that operators never stand on wet floors, and the maintenance of superior working conditions, all tend to lessen breakage. Important points to consider when buying a machine are the labor required, power, water heater and pressure, rack or belt conveyor, motor, table space, construction, whether or not trays and glasses may be washed in it, and the speed with which one may obtain service. Service is important, for no machine is perfect.

*How to Assure Dish Sanitation, Restaurant Manage. 29: 37 (July) 1936. Abstracted by Sammy Steele.

BOOKS ON REVIEW

SECURITY AGAINST SICKNESS. *By I. S. Falk, Ph.D. Garden City, N. Y.: Doubleday, Doran & Company, Inc.*, 1936, p. 431, $4.00.

In 1933, Doctor Falk, formerly associate director of studies of the Committee on the Costs of Medical Care, undertook to carry further the work of that committee by making more detailed studies of sickness insurance in other countries and of a possible plan for the United States. The survey of health insurance abroad not only involved the examination of a large number and variety of documents, both official and nonofficial, but also personal inquiries in eight foreign countries.

The present book is divided into three main parts. Part one deals with the need for group payment of sickness costs in the United States and is, in large measure, a concise summary of the extensive factual information collected by the Committee on the Costs of Medical Care.

Part two deals with the experience with health insurance in Great Britain, Germany, France and Denmark. Those who have learned about health insurance only from the propaganda put out against it by certain groups in this country will be surprised by the large degree of success here revealed. While Doctor Falk does not minimize in any degree the difficulties that have been encountered in the various European plans studied, his evidence strongly indicates that sickness insurance has been an inestimable boon to the people for whom it is designed.

The third section is entitled "The Basis of an American Program." It includes conclusions from health and sickness insurance in foreign countries, a review of workmen's compensation insurance in this country, an analysis of the relative merits of voluntary and compulsory insurance and suggested basic principles for an American program. Much can be learned from our own experience with workmen's compensation that will be of value in planning for more extensive health care. But it would, in Doctor Falk's opinion, be a great mistake to make present workmen's compensaton laws the basis of a general health service.

Those who wish health insurance to be a "poor man's system" will find little comfort in this volume. The necessity of separating cash benefits from medical benefits and of including a sufficient percentage of the population so that the medical benefits may be of high quality and ample scope is clearly set forth.

No serious student of American health problems should fail to read Doctor Falk's excellent book. It presents in lucid and scholarly fashion the point of view of those who believe that health is a first concern of a nation and that a health insurance plan can be created in America that is superior to anything thus far appearing in Europe.—ALDEN B. MILLS.

ILLUSTRIOUS CONTRIBUTORS TO PUBLIC HEALTH. *By Charles Frederick Bolduan, M.D. Department of Health, New York City. Privately printed*, 1936. *Pp.* 33.

The new municipal building, housing the New York City departments of health, hospitals and sanitation and the office of the chief medical examiner, contains spaces for the names of twenty-nine illustrious contributors to public health. The twenty-nine selected by a committee of the New York Academy of Medicine range from Moses, who prepared the first sanitary code, to William H. Welch and Herman M. Biggs. Doctor Bolduan gives in this souvenir volume a brief account of the activities of each.

NEW PRODUCTS • • •

Rugs, All Wool and Nonslip

Sorry is the unwary patient who, upon getting into bed, braces himself against the bedside rug. The rug suddenly becomes mobile and dire is the result! But "Kenwoods," those new all-wool rugs by F. C. Huyck & Sons, Kenwood Mills, Albany, N. Y., are designed to prevent rug mobility, backed as they are with live, resilient sponge rubber. They are available as runners, scatter or bath rugs and in carpet size, in divers widths and continuous lengths up to 60 feet. Swatch cards are offered, showing colors and special backing.

Keeping Up With Casters

Jarvis & Jarvis, Inc., Palmer, Mass., follow closely the institutional caster scene. Comes news that they have improved and more than doubled their line of casters and wheels for hospitals. Their Super-Casters, for instance, are now easily secured to a bed leg or other piece of equipment by a mere turn of a wrench; further, it is said, the opening is sealed against germs, vermin, air, dust and moisture. Other new types are the single and double rubber expanding applicator casters, readily applied by merely gripping the top cap of the bearing. These are designed for bedside screens and other lightweight equipment. A new line, too, is the all-rubber wheels in sizes 1⅝ to 6 inches, for use in all casters; these formerly could be had only with steel disk rubber tired wheels. These are supplied with either hard or soft tread. New casters for stretchers, trucks and the like are now equipped for efficient lubrication in both swivel and wheel bearings and can be furnished with plain, ball and roller bearing wheels. Still others are medium heavy duty swivel and rigid casters with 1½-inch wide clincher grip rubber tires designed for trucks, food conveyors and like equipment. Finally, there is a product entirely new with Jarvis — a line of spring cushion glides, said to be noiseless on stone or any other type of floor.

Truly Portable Air Conditioner

For some years hospital superintendents have been hoping that some manufacturer would provide a truly portable air conditioner. A long step toward answering this hope has recently been taken by the Air Devices Corporation, 64 East 25th Street, Chicago. After extensive engineering research this company has produced a summertime air conditioner which cools, dehumidifies, filters and circulates summer air and does it all without requiring any plumbing connections whatsoever! Furthermore, this summer air conditioning unit can be easily moved in from fifteen or twenty minutes from one room to another on a small folding truck.

The unit consists of a half-ton refrigerating machine with a 1/20-horsepower motor fan. It is placed on the sill in the window. The fan pulls in air from outside as well as recirculates air from the room. Both types of air are filtered and cooled in the process and the 90 per cent of air which is recirculated is also dehumidified. The machine is heavy insulated and cushioned to eliminate sound and vibration as well as to exclude street noises.

The feature of this equipment that required extensive

engineering research is that the water taken from the air does not have to be passed down a drain but is collected and used to cool the condenser coil. In this process some of the water is evaporated and expelled to the outside air. A new type eight-cylinder compressor is used, which cuts down on heat generation, conserves space and reduces vibration. The one-half ton of refrigeration produced is sufficient for a room containing from 1,600 to 2,000 feet, depending upon the climate and the exposure.

It is reported that several hospitals have practically paid for the cost of these machines during the first year through having them available to patients on a rental basis.

Keeping Warm When It's Cool

Cannon Mills, Inc., 70 Worth Street, New York, plans for a busy blanket season. For instance, there is the new moderately priced Pelham blanket, all virgin wool and available in any of six solid colors: green, rose, orchid, blue, rust and tan. Then there is the new Highland blanket, also all wool, slightly higher priced than its companion, larger and available in a wider range of colors—among these, pastels such as peach and apricot. A soft, velvety finish is another reported characteristic of this satin-bound blanket.

A Tip From Squibb

A new aid to physicians treating bites inflicted by black widow spiders is offered by E. R. Squibb & Sons, 745 Fifth Avenue, New York. This company has developed "Antivenin," a serum prepared by the hyperimmunization of sheep with repeated doses of venom from this species of spider. Clinical reports and information as to dosage and administration are supplied by the manufacturer. Another new product of this firm is "Nitrazine," a sensitive indicator for use in titrimetry and for colorimetric determination of hydrogen ion concentration. It is available both as test solution and as a paper, samples of which, together with booklet and color chart, may be secured by those interested.

For Neater Radiographs

We are not surprised that Eastman Kodak Company, Rochester, N. Y., produced that new x-ray film corner-cutter. Too long have roentgenologists put up with sharp projections on x-ray films, caused by developing hangers. With the new cutter, square corners of any size of radiograph are quickly and uniformly rounded, it is said, and several radiographs may be trimmed at one time. A self-sharpening knife with protective guard, guide strips for holding radiographs so that uniform amounts are cut from corners, and a compartment to catch clipped corners as they automatically drop from the knife blade, are other features reported by the manufacturer.

First Aid for Wounds

In the emergency treatment of wounds, reflect Eli Lilly laboratory workers, consideration must be given promptly to both pain and danger of infection. Ideally, a local anesthetic and an antiseptic should be incorporated in the same vehicle. Moreover, such a vehicle should be water-soluble so that it can be washed away easily if the surgeon pre-

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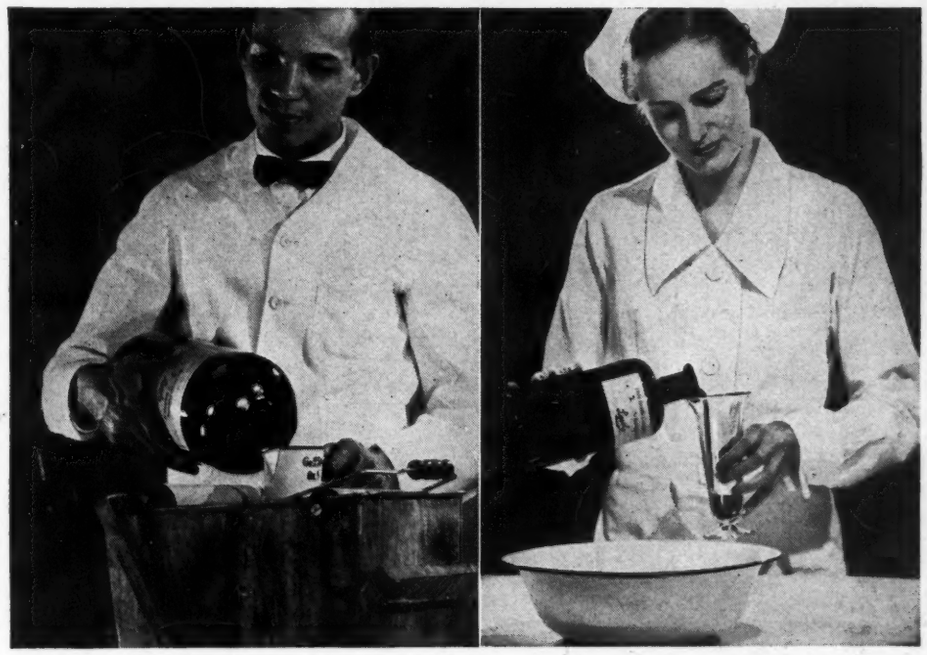

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Non-specific... "Lysol" gives you dependable disinfection... no free alkali... safe for tissue, fabrics, rubber and costly instruments... Saves up to $1.00 a gallon on these disinfecting costs.

IMPORTANT FACTS ON PHENOL COEFFICIENT!

THE Phenol Coefficient of a disinfectant compares the action of that disinfectant with the action of phenol on typhoid germs. But in general disinfecting, many types of disease-causing bacteria must be destroyed!

"Lysol" is non-specific. Its positive action on a wide variety of pathogenic bacteria is definitely known. Pine Oil and Coal Tar products may have a much higher Phenol Coefficient (with B. Typhosus) than "Lysol" but they have *little or no value* in the destruction of streptococci or staphylococci.

The Phenol Coefficient is an adequate measure only when used to compare chemically related disinfectants, such as cresol compound U.S.P. with "Lysol." Here "Lysol" with a Phenol Coefficient of 5, is twice or more than twice as potent as cresol compound U.S.P. (having a Phenol Coefficient of only 2 or 2.5). And this is true with many micro-organisms...not *only* typhoid germs.

"Lysol" is efficient and economical for all general disinfection. That's why hospital sales have soared 41% ahead of last year. Cut your disinfecting costs by buying "Lysol" in bulk. Standardize on "Lysol" for every disinfecting and antiseptic requirement!

NOTE: The chlorine type of disinfectant has not been considered due to its lack of stability. "Lysol" is stable.

As low as **$1.25** per gallon, on 50-gallon contracts, delivered 10 gallons at a time as required

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fers to use some other local application, incompatible in nature. As announced by Eli Lilly and Company, Indianapolis, the problem has been solved by creating a water-soluble jelly which incorporates the Lilly products, "Metycaine," for locally controlling pain, and "Merthiolate," said to be a satisfactory germicide, distinctive for its tissue compatibility. And the producer suggests including the new preparation in first-aid kits of ambulance or hospital.

Trade Literature

Eighteen Bulletins of Hospital Equipment — S. Blickman, Inc., a Weehawken, N. J., firm that is almost half a century old, is issuing a series of bulletins describing its varied line of hospital equipment. The series includes material on food conveyors, clinical furniture, autopsy tables, linen and waste receptacles, nursery furniture, hydrotherapeutic baths, laboratory and operating room equipment. In addition to standard and enameled finishes, this company features a wide line of stainless steel equipment, a metal which, as hospital people are reminded, is attractive and will not chip, crack or tarnish. An item fabricated of this metal, by the way, is a new bedside table made by Blickman completely — not just in part — of stainless steel. Another book, Blickman-produced, is "A Half Century of Achievement," designed to aid the buyer, architect, engineer and others interested in the selection of modern food service equipment. Basic features of planning and fabrication are illustrated by such examples of installations as cafeteria counters, bakers' and cooks' tables, plate warmers, coffee service equipment and dishwashing units.

Who and What in Curity Catalogues—Yours for the asking is a packet of circulars and catalogues depicting the latest in bandages, sutures, etc. Make your selection, suggests Lewis Mfg. Co., Div. of The Kendall Co., Walpole, Mass., from this group of titles: Selvage Gauze; Layettecloth Diapers for Hospitals; Bandages; Lisco and Dressing Rolls; Cotton Balls; A New Waterproof Adhesive, and a five-some of booklets on sutures, variously entitled Dermal and Tension Sutures, Gastro-Intestinal Sutures, Plain and Chromic Catgut, The Advance in Absorption Control and Sterilization and Bacteriological Control. Not as new, having made its bow a year or so ago, is a sizable spiral-bound book replete with descriptive detail, entitled "Curity: A Brief History and Complete Catalog of Products."

Concentrating on Anesthesia—A minimum of introductory fanfare characterizes a booklet recently released by The Heidbrink Company, Minneapolis. Straightforward statements, unvarnished, acquaint one with essential features of the varied line of Kinet-O-Meters, gas-oxygen anesthesia machines produced by this firm. Pictured and technically described are cart and stand outfits of four-gas and three-gas Kinet-O-Meter types, cyclopropane-giving apparatus, and cabinet outfits for three, four or five gases. The latter outfits combine in a single mobile unit the facilities of the Kinet-O-Meter with those of a spacious cabinet and an anesthetist's table.

Things to Know About Aluminum — The latest data on the safety of aluminum cooking utensils come from Aluminum Wares Association, American Bank Bldg., Pittsburgh, in a new file folder entitled "Health Aspects of Aluminum Cooking Utensils." Paragraphs appear to the effect that propaganda against the use of aluminum for cooking is without scientific foundation and a bibliography suggests articles to read on this subject.